FULL COMMITTEE HEARING ON THE PRESIDENT'S FY 2010 BUDGET AND MEDICARE: HOW WILL SMALL PROVIDERS BE IMPACTED?

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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FULL COMMITTEE HEARING ON THE PRESIDENT'S FY 2010 BUDGET AND MEDICARE: HOW WILL SMALL PROVIDERS BE IMPACTED?

Wednesday, March 18, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 1:00 p.m., in Room 2360 Rayburn House Office Building, Hon. Nydia Velázquez [chairman of the Committee] presiding.

Present: Representatives Velázquez, Shuler, Dahlkemper, Schrader, Kirkpatrick, Ellsworth, Sestak, Bright, Griffith, Halvorson, Graves, Westmoreland, Luetkemeyer, and Thompson.

Chairwoman VELÁZQUEZ. This hearing of the Small Business Committee is now called to order.

In the last few years, this Committee has heard from countless entrepreneurs who say healthcare costs are crippling their businesses. For many small firms, rising premiums have become a barrier to growth and success. So it was not surprising when the President used his February speech on the budget to make the case for reform. As he later put it at the White House Healthcare forum, "the greatest threat to our nation's balance sheet is the skyrocketing cost of healthcare."

As part of its budget for the coming year, the new Administration has made healthcare reform a top priority and with good reason. The current system is bankrupting businesses and costing our country $2.4 trillion a year. On a per capita basis, Americans spend 250 percent more than any other advanced nation. Clearly, the system is broken, and we cannot continue down this path.

For decades, this country has been waiting for comprehensive healthcare reform. Now that it is finally becoming a reality, we are going to see some very real changes in the system, especially for small businesses. This afternoon, we will review many of those proposals, and hear from the individuals who will be handling them day in and day out. Their views will give us the insight we need to start determining next steps.

Healthcare reform affects entrepreneurs on many levels. To begin, it helps ease the burden of rising insurance costs, which have jumped 129 percent in the last eight years. With premiums growing four times faster than wages, the need for change has never been greater.

Small medical providers, who are the core of our healthcare system, will also have a critical role in reform efforts. Small businesses makeup nearly 70 percent of all healthcare practices and they recognize that the current system is simply not working. These are the entrepreneurs who will be implementing change, and they are the people spearheading the process.

A key component of reform is an increased emphasis on efficiency. That includes streamlining the system and modernizing it through a greater use of Health IT. Additionally, it means cutting expenditures such as Medicare overpayments and hospital readmissions. As a result of these measures, Americans should see an estimated $316 billion in savings. Those savings will go a long way in ensuring that every American has access to quality, affordable coverage.

The budget provides a clear outline for reform. However, President Obama has said he is not rigid in those plans, and welcomes innovative ideas from all around the country. After all, our healthcare system touches the lives of every single American. Rather than taking a one-size-fits-all approach, reform should account for a broad range of interests. This is particularly true when it comes to the unique needs of entrepreneurs.

Like all other business owners, the providers here today are stakeholders in the movement towards greater healthcare coverage. They are also the men and women in the trenches, making sure that the system works for everyone. Their input will be an invaluable asset to the reform process, and I look forward to hearing their suggestions for next steps.

I would like to thank today's witnesses in advance for their testimony. And I am glad you were able to take time out from running your businesses to discuss this important issue.

With that, I would like to yield to Ranking Member Mr. Graves, for his opening statement.

Mr. GRAVES. Thank you, Madam Chairwoman, thank you for holding this hearing on the changes to Medicare that are proposed in the President's budget. Thank you for delaying the hearing just slightly.

I want to thank our witnesses for all being here. You all are very much experts in the area of healthcare reform and I know some of you have traveled a ways and I appreciate you being here.

We are a nation that is certainly concerned about healthcare. Forty-five million Americans are with health insurance. For those who do have insurance, and can afford to pay the premiums, the costs are rising. And for small businesses, the problem is even more challenging: how to operate a small company in a worsening economy, while continuing to attract and retain the best employees, which means offering competitive salaries and benefits.

Small businesses are committed to offering healthcare to their employees, but many are concerned about the proposals in the President's budget. The budget recommends spending $634 billion over the next 10 years to create a reserve fund to help finance healthcare reform, although some estimate the cost of universal coverage and other reforms could actually $1.2 trillion.

That $634 billion reserve fund comes from several sources. First, it comes from raising taxes on individuals earning more than

$200,000 a year and couples earning more than $250,000 a year; many of whom are small business owners, and who tend to return any profit back to their businesses. Second, it comes from cuts or changes to Medicare or Medicaid payments. But even the budget itself notes that the sum will be insufficient to accomplish healthcare reform and is a mere "down payment." Exactly how much more will be needed, and the source of these additional funds is not disclosed.

To its credit, President Obama's healthcare budget recognizes the significant problem with unsustainable growth and entitlement spending. However, the budget also includes an enormous expansion of costly entitlement programs. This is at a time when spending levels on our current entitlement programs, such as Medicare and Medicaid, are simply unsustainable.

Small business issues—you know, the fact is, small business issues are non-partisan. We can all support strengthening America's small companies, which are the job creators of our economy. We can all support the goals of increasing access to affordable health insurance and increasing the quality of outcomes. We must also, however, ensure that America's small business owners have the tools they need to grow and lead our nation's economic recovery, and are not unfairly burdened with the additional taxes, mandates or regulations.

Again, Madam Chair, I want to thank you for holding the hearing and I look forward to what the witnesses have to say and I appreciate you holding up just a little bit.

Chairwoman VELÁZQUEZ. Thank you, Mr. Graves. I welcome the first witness, Dr. Joseph Heyman. He is a Board-certified obstetrician/ gynecologist, practicing for over 30 years. He has a private practice in Amesbury, Massachusetts. Dr. Heyman has been a member of the American Medical Association Board of Trustees since 2002 and is currently serving as chair. The AMA represents the American medicine industry and serves as an advocate for the physician, the patient, and the profession.

Welcome, sir. You have five minutes to make your statement.

STATEMENT OF JOSEPH M. HEYMAN, M.D.

Dr. HEYMAN. Thank you, Madam Chairwoman. My name is Joe Heyman and I am Chair of the Board of Trustees of the American Medical Association, also a gynecologist in solo practice in Amesbury, Massachusetts. The AMA thanks you, Chairwoman Velázquez and Ranking Member Graves, and members of the Committee for your leadership in holding this hearing.

America's seniors, the physicians who care for them, many of whom, like me, are small business owners, and Congress, all face an annual Medicare problem. The current Medicare physician payment formula, known as the Sustainable Growth Rate, or SGR, ties physician payments to the GDP. Yet, while the economy is going down, the healthcare needs of seniors are going up. The SGR is not reality and has threatened steep cuts every year since 2002.

Over the last six years, Congress and the physician community have had to scramble to achieve multiple eleventh hour interventions to ward off these cuts and preserve patients' access to care. And now, due to the SGR, a 21 percent cut is scheduled for Janu-

ary 1st, with cuts totalling 40 percent projected in the coming decade. These cuts, if not stopped, will impair patient access. The vast majority of physician practices are small businesses and cannot absorb these steep losses. No small business could survive under a business model that dictates steep cuts year after year. A solution is needed now.

The Administration's budget provides a big part of the solution. It assumes a new baseline in forecasting future spending on Medicare physician services. This is known as rebasing. And we strongly support it. With rebasing, the Administration uses a new baseline to reflect the realistic assumption that Congress will continue to preserve seniors' access to care by stopping future SGR cuts. After all, the primary purpose of the budget baseline is to provide policymakers with the clear forecast of projected spending and taxpayer obligations.

In previous years, budget forecasts have inaccurately assumed that the projected 40 percent in physician cuts would occur. In reality, Congress has interceded six times since 2003 to legislatively ignore the physician payment baseline and provide temporary payment increases.

Rebasing is imperative for several reasons. It would pave the way for Congress to repeal the SGR. Congress could then establish a new Medicare physician payment system that allows annual updates that accurately reflect increases in medical practice costs with appropriate incentives for utilization, efficiency, and quality. This two-step process, that is, rebasing along with repeal of the SGR, will preserve access to high-quality, cost-effective healthcare for our senior and disabled patients.

And since projected SGR cuts exacerbate on-going physician shortages, rebasing and repeal of the SGR will favorably affect the future supply of physicians. Further, adopting a new baseline and repealing the SGR means physicians and Congress can focus on other important reforms like health insurance for the uninsured, adoption of health information technology, and investment in quality improvement and prevention programs.

Finally, a new baseline and positive physician updates would bolster our economy. It would help sustain the jobs of nearly three million employees and benefit millions of patients and physicians across the country. For example, if the 40 percent cut takes effect, New York would lose $17 billion by 2016 for the care of elderly and disabled patients. And Missouri would lose $4 billion. And every state represented on this Committee similarly would stand to lose billions. The stakes are too high to continue this cycle of eleventh-hour, temporary SGR fixes.

We urge the Committee and Congress to support adoption of a new baseline in the Fiscal Year 2010 budget resolution and pave the way for a new Medicare physician payment system that best serves patients and employees across the country, as well as our entire healthcare system.

Thank you very much for the opportunity to be here today.

[The statement of Dr. Heyman is included in the appendix at page 36.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Heyman.

Our next witness is Dr. Jeffrey Harris. He has practiced Internal Medicine and Nephrology since 1977 and is currently a faculty member of the University of Virginia Medical School. He is representing American College of Physicians where he serves as President. The American College of Physicians is the largest medical specialty organization and the second largest physician group in the United States. Welcome.

STATEMENT OF JEFFREY HARRIS, M.D.

Dr. HARRIS. Thank you, Chairwoman Velázquez and Ranking Member Graves for allowing me to share the American College of Physicians views regarding the President's healthcare budget for Fiscal Year 2010.

As mentioned, I'm Jeff Harris, President of the ACP. Until recently, I practiced in a rural community with a population of 40,000. The office in which I practice focused on the delivery of primary care and Nephrology. I have practiced Internal Medicine for nearly 30 years. This year I have the good fortune of being President of the American College of Physicians, representing 126,000 Internal Medicine physicians and medical students. The ACP is the largest physician specialty organization in the United States.

Smaller physician practices are an essential part of the system of care in the U.S. Congress has a historic opportunity to adopt a budget that will help physicians in small practices provide the best possible care to patients by (1) eliminating payment cuts from the Sustainable Growth Rate, known as SGR, and accounting for the true costs associated with providing updates that keep pace with the practice of medicine and its costs; secondly, increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices; and thirdly, funding programs to support and expand the patient-centered medical home.

Over the past several years, one of the College's main priorities has been urging Congress to reform the SGR, Medicare's flawed physician payment formula. This formula has led to scheduled annual cuts in physician payments for each of the past seven years. This coming January, as Joe mentioned, physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert the cut.

Since this is a hearing of the Committee on Small Business, the following analogy may help illustrate the problem. Imagine you work for a small business and imagine that your boss told you that your wages would be cut by 10 percent this year. Later, your boss announces that your company will not cut your wages, but that the only way the company can afford to stop the 10 percent cut would be to pretend to reduce your wages by 20 percent the following year. You were told not to worry though. They would just do the same thing the next year, prevent the 20 percent cut by pretending that the costs will be cut of your wages by 40 percent the following year. You were told though that the company has no intention of ever allowing a 40 percent cut to happen. They just have to pretend they will do so so the accountants will allow them to stop the immediate pay cut. And on and on it would go.

No small business would actually run its payroll budget this way. Yet, this is how Washington has handled costs associated with stopping the SGR, up until now that is. President Obama's budget is a marked departure from past practices because it acknowledges what we all know to be true which is that preventing pay cuts to doctors will require that the Medicare baseline spending be increased accordingly. Once the true costs are accounted for in the budget, Congress and the Administration would enact a long-term solution that will permanently eliminate the SGR as a factor in updating payments for physician services.

Instead, payment updates should provide predictable increases based on the cost to practice of providing care to Medicare patients. This is especially important for physicians in smaller practices. Also, the primary care shortage is escalating at a time when the need for primary care physicians is greater than ever. Our aging population further increases the demand for general internists and family physicians.

Congress should enact Medicare payment reforms so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings potentials.

Currently, primary care physicians, on average, earn 55 percent of what non-primary care specialists earn on average. Is it a wonder then why only two percent of fourth-year medical students plan to go into general Internal Medicine, one of the two specialties that adults depend upon for their primary care.

The College believes that a reasonable goal would be to raise primary compensation to the 80th percentile of the compensation of other specialties. This will require that Medicare and other payors increase primary care reimbursement by seven to eight percent per year over the next five years. Such an investment in primary care will result in better health and lower cost of care. To illustrate, a recent study in the American Journal of Medicine found that a higher ratio of primary care physicians in areas was associated with fewer hospital admissions, emergency department visits, and surgeries. Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases for primary care.

The patient-centered medical home enjoys support of a wide range of healthcare stakeholders. Policymakers view it as a promising reform model with Congress authorizing the Medicare medical home demonstration project through a 2006 law and supplementing it with a dedicated funding and increased ability for expansion through a 2008 law. The current Medicare medical home demonstration, which is limited to eight states, should be expanded to a national pilot with increased funding to allow for such expansion.

ACP is grateful for the opportunity to share its views regarding the President's budget and looks forward to working with you to improve the quality and lower the cost of our healthcare system.

Thank you.

[The statement of Dr. Harris is included in the appendix at page 42.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Harris.

Our next witness is Dr. John T. Preskitt. He is a general surgeon in private practice at Baylor University Medical Center in Dallas, Texas. He also serves as head of surgical oncology in Simmons Cancer Center. Dr. Preskitt is a member of the American College of Surgeons and currently serves on the Board of Regents. With more than 74,000 members, ACP is the largest organization of surgeons in the world. Welcome.

STATEMENT OF JOHN T. PRESKITT, M.D.

Dr. PRESKITT. Chairwoman Velázquez, Ranking Member Graves, and Members of the Committee, thank you for holding this very important hearing on Medicare policy proposals included in the President's budget and their impact on small businesses. We very much appreciate having our practices considered as small businesses which they certainly are.

I'm John Preskitt. I'm a general surgeon. I've been in private practice at Baylor in Dallas since about 1981. I'm in a group of seven surgeons, five of whom work downtown. As stated before, we're very honored to represent the 74,000 members of the American College of Surgeons, the largest surgical organization in the world and to testify regarding the President's budget.

There are five issues I'd like to briefly touch upon. Certainly, Medicare has been discussed and I won't repeat the very eloquent review of the SGR and its impact, but surgical practices do receive about 38 percent of their revenue from the Medicare system, which is a broken system as has been emphasized. I'm thankful for this Committee and the Congress for passing MIPPA 2008 which rolled back the proposed cut that would have occurred last July. And we very much appreciate the emphasis the President's budget has set on resetting the budget baseline for that SGR.

Quality improvement is also an extremely important issue for the American College of Surgeons. And I will just say that Dr. Harris and I both refer to our organizations as the College, so I apologize, but it's easier than saying the whole thing. But we stand for patient safety, assuring high quality, effective care and providing healthcare value for our patients. The American College of Surgeons has established the National Surgical Quality Improvement Program with the acronym NSQIP which was developed from the very highly successful Veterans Affairs program. It provides statistically-valid, 30-day, risk-adjusted outcomes. In the VA system, the NSQIP program allowed for a 27 percent reduction in 30-day mortalities by simply looking at these outcome measures.

Currently, it is in use in 220 academic and community hospitals. The Joint Commission includes a merit badge next to the profile of all ACS NSQIP hospitals.

Physician ownership in specialty hospitals and ambulatory surgery centers, though an area of legitimate concern raised by the actions of a few entities, has also in many cases, including my own State of Texas, complemented the community hospitals and these facilities have received very high quality scores in patient satisfaction. Nonetheless, the American College of Surgeons feels the owners of those facilities should function under the following principles: accept payment without regard to means of payment by the patient; select patients based on their actual expertise of the facility,

and not extend care beyond that. All surgeons involved in such endeavors should continue to provide emergency coverage in their community hospitals. The issue of having an ER in a specialty hospital should remain a matter of state law and community need. And as important as the rest, physician investors should always disclose their financial interests to any and all patients.

The supply of surgeons, especially general surgeons is diminishing. As we're getting older, some of us are getting much older, it's been documented in the text the College would propose the following measures and these are applicable to all medical specialties: Preserve Medicare funding for graduate medical education; eliminate residency funding caps; extend the funding through initial Board eligibility; include surgeons under Title 7 of the Health Profession Program, including the National Health Service; alleviate the burden of medical school debt through loan forgiveness programs that stipulate work in rural and undeserved areas; extend the medical student loan deferment to the full length of that training; and consider supporting the physician workforce and Graduate Medical Education Enhancement Act, H.R. 914, which Congressmen Burgess and Green have proposed to establish interest-free loan for programs in hospitals starting new residency training programs.

In summary, the College greatly appreciates this opportunity to testify regarding the budget and its impact on the surgical practices and patients' access to surgical care.

Thank you very much, Chairwoman.

[The statement of Dr. Preskitt is included in the appendix at page 53.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Preskitt. And now I recognize Mr. Shuler, for the purpose of introducing your next witness.

Mr. SHULER. Thank you, Madam Chair. It's an honor and a privilege to introduce a constituent, Ed Hannon. He is the President and CEO of McDowell Hospital in Marion, North Carolina. He is here today on behalf of the American Hospital Association.

In his role, he oversees a rural hospital, home health agency, rural health clinic, and physician services. He has over 20 years' experience in hospital and healthcare systems and outpatient services.

Mr. Hannon, thank you so much for your participation in the hearing today.

STATEMENT OF EDWARD HANNON

Mr. HANNON. Congressman, thank you. Madam Chairwoman, thank you, and I appreciate the opportunity to address you all today.

I am Edward Hannon. I am the CEO of the McDowell Hospital in Marion, North Carolina and chairman of the American Hospital Association's Governing Council on Small or Rural Hospitals. It's a pleasure to be here today, to speak to you on behalf of the nearly 5,000 members of the American Hospital Association.

McDowell Hospital is a 65-bed rural, not-for-profit hospital located in the foothills of the Blue Ridge Mountains of Western North Carolina. While the recession has touched us profoundly in

our area of the country, we are steadfast in our commitment to reform healthcare, which should start with expanding coverage for all. And we commend President Obama for making healthcare reform a top priority.

Hospitals have been early and ardent supporters of efforts to make healthcare more affordable. We have worked to increase the focus on wellness and prevention, better coordinating care, utilizing comparative effectiveness research, moving towards the adoption of information technology, creating alternative liability systems and reducing administrative costs.

However, we urge Congress to carefully consider the impact that it will have on all hospitals, including the small and rural facilities.

There are three main characteristics that differentiate the small and rural hospitals: our small size and volume, our geographic isolation, and the type of population that we serve. First, lower patient volumes in rural hospitals mean that our financial position is more volatile which complicates our abilities to position ourselves, develop accurate long-range financial plans and contingency plans. As a result, we're less able to weather the financial fluctuations, especially in today's economy.

Next is geographic isolation. Rural communities across the country are self-contained and far from population centers and other healthcare facilities. In my case, the closest hospitals are more than 30 miles away to the west of us, across the mountains, and 25 miles to the east of us. Moreover, public transportation is practically non-existent. For many rural residents preventive, post-acute, and other services may be delayed or forgone, ultimately increasing the overall cost of care.

Finally, America's rural areas tend to have higher proportions of Medicare patients. For example, Medicare accounted for 58 percent of the discharges from my hospital in 2008. Any payment change to this program would therefore hit us especially hard. Our lower revenues and tight margins means we're less able to subsidize any losses.

Now that you have a better picture of the challenges faced by small and rural hospitals, I'd like to outline how the President's proposed budget would affect U.S. The President's budget proposed reducing payments to hospitals where high numbers of patients are readmitted within 30 days. However, any policy that assumes that most hospital readmissions are preventable raises concerns. Determining preventable readmissions is complex because the causes behind each readmission are unique. Such a policy requires thorough analysis of both the patient's hospital experience and the care prescribed for that patient after they're discharged. Further, some readmissions are planned and appropriate patient care, such as for chemotherapy patients. Any provision that does not recognize these legitimate reasons for readmissions may become an obstacle to patient care and patient safety.

The budget outline also proposes to bundle payments for hospitals and post-hospital acute care. While we welcome a careful and thoughtful approach to bundling, we first need to evaluate existing demonstration projects and gradually phase in implementation with appropriate tools and infrastructure for coordinating care and managing these risks. Some hospitals and healthcare systems al-

ready are organized in such ways that this would facilitate the bundling of payments, but many are not. Many of the bundling pilot projects focus on care that is not even commonly provided in rural hospitals such as coronary artery bypass graft surgery. A thorough understanding of the unique obstacles of rural health must be undertaken before any of these new programs are put into place.

It is critical that we shape a fair payment bundling system.

The President's budget also proposes linking a portion of the inpatient hospital payments to performance on specific quality measures. Providing incentives for quality is a laudable goal that we certainly support. The fact is hospitals more than any other provider type have a history of linking quality measurements and improvements to payments. However, we are concerned about this proposal because it cuts payments up front. We believe that overall savings can be reached by improving care that leads to fewer medical visits. The current pay-for-performance proposals use a standard set of measures which may involve procedures not performed commonly at small and rural hospitals. A way to address low volume situations must be included in any pay-for-performance proposal.

Before I conclude, I do want to offer the AHA's full support for several provisions of the President's budget outline. The President proposes to permanently fix the Medicare physician fee schedule, and to invest $330 million to address the shortage of healthcare providers in medically-undeserved areas, which would enhance our ability to recruit and retain physicians. In addition, we strongly support the President's inclusion of a ban on physician self-referrals to hospitals in which they have ownership interest. We look forward to working with the Administration and Congress to achieve this goal.

Let me end by saying that hospitals are more alike than we are different. Together we form America's healthcare safety net no matter the size of our staff, the size of our budgets or location. Our mission is always the same, to treat everyone the best of our ability each and every day. Thank you for your time today and I appreciate the opportunity to be here.

[The statement of Mr. Hannon is included in the appendix at page 63.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Hannon. Our next witness is Dr. Robert E. Moffit. He is the Director of the Heritage Foundation Center for Health Policy Studies. Dr. Moffit has been a veteran of Washington policymaking for more than 25 years. In the Foundation, he specializes in medical reform, health insurance and other health policy issues. The Heritage Foundation was founded in 1973. Welcome.

STATEMENT OF ROBERT E. MOFFIT, Ph.D.

Dr. MOFFIT. Thank you. Thank you very much for the opportunity to talk with you today. It's an honor and a privilege to appear before the Committee. The views that I express today are entirely my own and should not be construed as representing the views of The Heritage Foundation or its officers or its Board of Trustees.

President Barack Obama has outlined an ambitious and far-reaching healthcare agenda, including major changes to the Medicare program. I would only observe at the outset that the decision to start with $634 billion worth of financing in a reserve fund without a clear understanding of what exactly it is that would be financed beforehand is at the very least an unusual approach. I would just make two observations in this connection. While the President may believe that there is enough of an agreement to jump start the process by putting the money upfront and hammering out the details later, it is a common experience in this area of public policy, in particular, that it is the details that drive broad policy agenda. It is not always the broad policy agenda that drives the details.

Secondly, with funds already committed to the project, there is always the danger that existing stakeholders, the representatives of a very powerful class of special interests that dominate this sector of the economy, will view this entire effort as merely a way to expand existing public and private institutional arrangements with additional taxpayer dollars, rather than the process of securing a real structural change in the healthcare system, the creation of different ways of improving the financing and delivery of healthcare for the 300 million Americans who are going to be the beneficiaries of reform.

All together, the President is proposing a dozen Medicare-related changes. In the limited time available to me, I would like to focus my remarks on just a few key Medicare-budget policy proposals. The President wants to change the Medicare Advantage system and this change will result in a substantial savings over the first ten years of this implementation. He wants to replace Medicare Advantage payment with a system of competitive bidding.

Ladies and gentlemen, much would depend on exactly how this legislation is crafted, the details of the process, and what the Administration specifically means by competitive bidding. It is a phrase that can, in fact, have very different meanings. If the process is a way for the government to pick winners and losers among health plans, something akin, for example, to a Department of Defense procurement process, it would be incompatible with personal choice and market competition. It is well to recall that the provision of that opportunity, particularly for seniors in rural areas is one of the major reasons why Congress enacted the Medicare Advantage program in the first place. If, however, it is a way of establishing a much more rational benchmark for Medicare payment, and allowing persons to pick richer plans and pay for the extra benefits, if they wish to do so, or picking less expensive plans and keeping the savings of their choice, the President's proposal could be a significant improvement over the current system.

The President would also make wealthy seniors pay higher premiums for prescription drugs. According to the press reports, the seniors enrolled in Medicare Part D would pay higher premiums just as seniors do in Medicare Part B. All together, certainly as an alternative to cutting provider reimbursements, income-relating medical subsidies is a sound alternative. The President's position makes a great deal of sense.

The President is calling for a re-evaluation of the current provider payment system. That is welcome. He is promoting pay for performance in accordance with government guidelines, tougher enforcement for Medicare payments to doctors and other medical professionals to reduce waste, fraud, and abuse in the system. It should be noted that Medicare savings have previously been proposed as a way to finance comprehensive healthcare reform. President Clinton proposed that in 1993, promoting a shift of approximately $124 billion over six years to finance his healthcare reform.

If the President's changes, however, simply results in additional reimbursement reductions at the end of the day, they would aggravate the current level of cost-shifting from federal entitlements to individuals and families in the private sector. Shifting tens of billions of dollars on to the private sector does not add one red cent to the value of healthcare in the United States.

I am pleased to hear that there is renewed discussion of the current tax policy governing health insurance. This could open up a new opportunity to forge a bipartisan consensus in healthcare policy. Senator Max Baucus has proposed capping the current tax exclusion on health insurance, the benefits of health insurance, and creating an opportunity for tax credits or perhaps a voucher program for low-income people to get insurance. This could be the basis of a serious bipartisan cooperation on solving one of the greatest single problems facing the American people.

Madam Chairwoman, I'm going to conclude my remarks, but I'll be very happy to answer any questions.

[The statement of Dr. Moffit is included in the appendix at page 70.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Moffit.

Dr. Harris, can you talk to us how will the practice of medicine be impacted if Congress fails to fix the Medicare physician payment system?

Dr. HARRIS. If they fail to and continue simply doing what's been done, namely masking the problem, all we're doing is putting off the inevitable. I mean this year, as you mentioned, we anticipate a 20 percent cut if it is not resolved. That will be 40 percent the next year. If you carry that to its logical extension, if Congress continues simply to apply a patch, that means by 2012 all the medical practices in this country are to be cut by 160 percent. I mean that is obviously utterly absurd.

So we, even today, if you were to cut it by 20 percent, I think you can say and this is not hyperbole, I don't thinkany primary care practice in this nation could survive a 20 percent cut in those revenues.

Chairwoman VELÁZQUEZ. Thank you. Dr. Heyman, the Medicare Advantage program costs the federal government about 14 percent more to provide benefits than traditional Medicare. The President believes the funding could be put to better use. Can you tell me where the medical community sits on this issue and I would like to hear from Dr. Harris and Dr. Preskitt and even Mr. Hannon.

Dr. HEYMAN. Well, at the American Medical Association, our feeling is that these are enormous subsidies in payment to Medicare Advantage plans. We're not opposed to Medicare Advantage plans

and we certainly are not opposed to people having the choice of regular Medicare or a Medicare Advantage plan. We just feel that if a Medicare Advantage plan was as efficient as Medicare is, then Medicare Advantage plans would be able to exist without those kinds of subsidies. And so we think an efficient Medicare Advantage plan is a wonderful idea. We just are opposed to giving them extra money to provide the same services.

Chairwoman VELÁZQUEZ. Dr. Harris?

Dr. HARRIS. The American College of Physicians would echo that sentiment. Again, we're not opposed to Medicare Advantage, what we would like is the various Medicare options that patients have on a relatively level playing field.

Dr. PRESKITT. The American College of Surgeons also has no issue, per se, with Medicare Advantage plans. The intent from the outset was to use a business model for the insurance industry, as I understand it, to provide more efficient care for Medicare recipients. We can't demonstrate that that has necessarily occurred. The President's budget proposal talks about comparative effectiveness research and sets aside money to do this, to figure out what is a value-based purchasing. And hopefully, Medicare Advantage plans will be driven to demonstrate a value in this purchasing. I don't believe we're there yet. And I would have to agree with my colleagues.

Chairwoman VELÁZQUEZ. Mr. Hannon?

Mr. HANNON. Madam Chairwoman, as small rural hospitals, we don't see the effects of the Medicare Advantage program in our communities as much as our urban counterparts do. As hospitals, it is not necessarily the program that's administered to us that makes a difference. It is where is the money being put to use? If it is, in fact, an efficient program, whether it's the Medicare Advantage program or any other one, our efforts are to ensure that patients get safe, appropriate care efficiently and that the money is going to help assume that the patient is getting the care and not to the insurance companies.

Chairwoman VELÁZQUEZ. Thank you. Dr. Harris, the ACP supports incentives for physicians who adopt HIT. However, there is concern of possible penalties for small and rural providers. Given the unique needs of these practices, how do you think we should address the issue of HIT?

Dr. HARRIS. This is a major issue. I would just preface it by saying that 82 percent of all the office visits in the United States are to practices with five or fewer physicians. I mean these are huge issues for small businesses. And HIT, the cost of it, is just an enormously steep hill to climb. As most of you are aware, the cost currently for a physician to add this technology to his or her office is about $35,000 to $50,000 per doctor. And then after that, it's another $5,000 per doctor per year to maintain the software. So obviously, with these groups of five or fewer, it's just a huge sum of money to try and find someone to loan you the money to go out and try and purchase the system which is so utterly essential if we're going to make the seamless connection which we believe ultimately will help reduce healthcare costs.

Chairwoman VELÁZQUEZ. Thank you. Mr. Graves?

Mr. GRAVES. Thank you, Madam Chair. When it comes to the IT system, I'm very interested in this because I have a medical IT company in my District, but I'm very curious as to if we can afford this. And I'm worried about particularly, and Mr. Hannon, I'd be curious too, because I represent a very rural District with very rural hospitals. And they seem to be as worried as anybody as about how they're going to implement this.

My question too is the point where all these systems are going to communicate with each other. I know there's different systems out there and being able to talk to one another is something that concerns me, but the bottom line is can we afford it right now? I mean we've got so many things on our plate with increasing healthcare costs and I'm just worried about that, where this thing is going. I'd like for you all to comment, but Mr. Hannon, I'd like to hear you first.

Mr. HANNON. Thank you, Mr. Graves. Congressman, the hospitals believe that we are early adopters and seek new technology. And it is our belief that health information technology is important for us to the future. You have hit on the important points. How is it we're going to be able to afford it, especially in our small, rural hospitals, many of which are running at negative margins today. The money needs to come from somewhere upfront and our ability to fund those upfront costs is certainly concerning to the small and rural hospitals.

We believe that long term, the best thing we can do is to bring technology in. And it is our belief that over time we will see some returns on that and we can lower the cost of healthcare for all Americans if we had technology. If we're able to share information with our physicians even between communities and with other hospitals so we're not duplicating tests, and we are seeing what prescriptions patients are on, we believe that we can improve the care of the patient, provide a safer environment for our patients, and assist our physicians in caring even faster for those patients.

As we look at issues of how are we moving those patients from acute care facilities to post-acute care facilities, a part of what the President's budget proposes, that sharing of information is critical if we're going to reduce the cost of healthcare.

Mr. GRAVES. Dr. Moffit. We can just go backwards.

Dr. MOFFIT. Will health information technology save money? Will it be a way to significantly reduce healthcare costs? I don't think anybody really knows.

Congress passed a health IT investment of about $20 billion in the stimulus bill. You didn't have many hearings; in fact, I don't recall any hearings on that proposal when it was passed. I know that within the medical profession, evidenced by columns by members of the medical profession in some prominent newspapers, including The Washington Post this week, that there is grave doubt about whether, in fact, health information technology will save money.

One concern is that with the government superintending the development and the dissemination of healthcare, information technology, we may end up creating a regulatory straightjacket in this area which could undermine innovation in one of the areas of the economy where innovation is a daily occurrence.

As I say, I think the jury is out on this.

Mark Pauly, at the University of Pennsylvania, a top-ranked economist, has made the point on several occasions, and I think before Congress that the success of all this is kind of a ″what-if″ proposition; that is to say, what if you don't get the kind of cooperation from all of the members of the medical profession you need? Or the cooperation you need from different sectors of the healthcare industry to accomplish all of this? I mean there are a lot of factors here that go into whether or not this will actually bring about the kind of savings that many people hope will come about. I have no strong feelings on it. I think the jury is still out.

Chairwoman VELÁZQUEZ. Would the gentleman yield? Let me set the record straight. We not only conducted one, but several hearings, this Committee on HIT and the impact on solo practitioners and small business practitioners.

Dr. MOFFIT. I was only—

Chairwoman VELÁZQUEZ. I would invite you to read the record because it could be very enlightening.

Thank you for yielding.

Mr. GRAVES. Dr. Preskitt.

Dr. PRESKITT. Thank you very much, Just to add to this, health information technology certainly is important and we appreciate the President considering it and elevating its importance into the record. I don't know that the issue is just the cost savings with health information technology, but it is also improvement of patient care and safety. The President pointed out in one of his statements about the senior citizen who must remember his or her history at every doctor's office he or she may attend.

My father is 89, has Parkinson's. He's sharp, but he doesn't talk so fast. Things are going to be missed. If health information was part of the system where as Ranking Member Graves said, the interrelated pieces communicate, this should improve safety and secondarily the efficiencies. But I think improving patient care and making care that more efficient is as important as the money saved.

Dr. HARRIS. Mr. Graves, increasing access to health information technology is absolutely essential. When Congresswoman Velázquez a moment ago talked about how much more expensive it is here than abroad, including in those numbers is the fact that we have the dubious distinction of having the highest administrative costs on a per capita basis of any of those industrialized countries. It's 7.3 percent of all the healthcare dollars go there. So health information technology becomes potentially a critical way to reduce those costs.

Now more explicitly to your question about how do you pay for this, we believe that's what essential in paying for all of this is a dramatic expansion of the primary care base in this country. The data from the United States, from Barbara Starfield or Hopkins or the Dartmouth Atlas folks, are absolutely compelling. And the study that we did comparing us to 12 countries overseas and their healthcare systems is equally as compelling. As you expand the primary base, you see a reduction in costs as well as an increase in quality.

I would just leave you with one study that I think reflects this and I might add parenthetically and I know it's in your data, we just published an annotated version of 100 studies in the United States which make this point. But the one that comes to mind is one that's often cited from The American Journal of Medicine, just a couple of months ago, a fellow named Kravitz was the lead author. And they concluded that if you had a community of 775,000 or three quarters of a million, and they had about 35 percent of the physicians there were primary care physicians, in the country now, it's about 30 percent. Overseas, it's 50 percent, the ones that do it so much less expensively and better. But if you could just increase this community from 35 percent of its workforce to 40 percent, what you saw was a reduction of about 1500 hospitalizations per year for a savings of $23 million per year. You saw 2500 fewer visits to the emergency room. You saw 1500 fewer surgeries, by simply increasing primary care 35 percent of your workforce to 40 percent.

We believe that expanding healthcare coverage in this country and expanding the base of primary care physicians are absolutely inseparable.

Mr. GRAVES. And we'll come to that. I agree with that. I'm trying to figure out how to get—when it comes to IT, because I'm worried about these small hospitals and how we're going to get there. I think it's important, particularly in the rural areas to bring technology because it adds some resources that we don't necessarily have. I just don't know how we're going to get there and how we're going to pay for it in an environment where it's increasingly—the costs are going up all the time.

Dr. Heyman?

Dr. HEYMAN. I have some personal experience with this. I've had an EMR in my office and used no paper since 2001. The EMR that I purchased still is the same one. It's a lot more robust now than it was when I purchased it in 2001. But there's no question that in my practice it definitely saves money. It definitely makes me more efficient. It definitely prevents mistakes. And it's very, very effective.

We kept hearing about how the federal government wanted to have more IT, but for the first time there's actually some money here and that's very important.

The other thing I would say is that there are a lot of barriers to this. In my community, we're very fortunate because we had a grant where every physician in my community now actually over the last three years has actually been able to have their own EMR in their office and we're supposed to be starting a help information exchange. Now one of the barriers is that the standards are not there and we have six different EMR vendors in our community. The physicians are supporting this health information exchange. All of these are CCHIT-certified vendors which means that they're supposed to be able to talk to each other and yet in each and every case, we have to come up with an interface of making them talk to each other and it's very expensive and we're not sure how we're going to be able to make that exist in the future.

I would also point out to you that physicians are always the first people to accept new technology. They're the first people to use cell

phones. They're the first people to use robotics in their practices. There are all kinds of technologies that physicians have used. There has to be a reason why physicians have not adopted this technology.

And the last thing I would say is that when physicians are incorporating this into their practices we found in our community that in spite of the fact that it was free, they got the hardware and the software for nothing, it was still very costly for those who were changing work flows in their practice to be able to incorporate this stuff into their practice.

So we definitely support the idea of increasing health information technology. We think it's inevitable in medicine, but there are barriers. We need those standards done by the end of this year and we think that it really will improve healthcare in this country if we do this.

Mr. GRAVES. I thank you all. And I think it will improve it too, but we still haven't figured out how to answer the question. The money is there, at least a little bit of it at the moment, but still how do we pay for it is the question that I have. If it's the result of savings, it would be good, but just encourage you all to think about that. We have to figure out how to pay for this.

Thank you, Madam Chair.

Chairwoman VELÁZQUEZ. Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, Madam Chair and thank you to our panel. I represent a vast, sprawling District in Arizona that's very rural and for over 20 years of my private law practice I represented the regional hospital and many physicians' groups, including our emergency physician group, so I thank you for being here. Healthcare reform and provision in rural areas is very, very important to me.

My first question is for Dr. Heyman and Dr. Preskitt regarding the SGR being tied to the GDP. And I'd like to know if there are other factors that you think would provide a more accurate baseline? So maybe we'll start with Dr. Preskitt and then go to Dr. Heyman.

Dr. PRESKITT. Well, I hope there are other factors that provide a more accurate baseline. My life, my expenses, my house payments, they don't follow the GDP. They seem to follow some other issue that might be related to consumer price index. I don't want to belittle the complexity of the math, but I just have to say there's one thing we've proven; tying payments to the SGR and how that relates to the GDP just isn't taking care of the process. It's not keeping up with any form of expense increase.

What we pay our employees in these small businesses, there's no way a single parent could have a job and be employed in a practice that followed the variation in salary if it followed the SGR. I think establishing a fixed base as the President has recommended is the place to start, but of course, that still means we have to fix the formula. I'm not giving you a direct answer, but we know that the current system is so incredibly broken that it's harming people.

Ms. KIRKPATRICK. Dr. Heyman, thoughts about that?

Dr. HEYMAN. Well, of course, there's the medical economic index which is an evaluation of the cost of providing care. That would certainly be a better index, if we're going to use indexing.

Ms. KIRKPATRICK. Who prepares that index?

Dr. HEYMAN. Is that from the CMS or the—I believe it is, but I'm not positive.

Ms. KIRKPATRICK. I'm a new member, so please bear with me.

Dr. HEYMAN. The other thing I was going to mention is that you know, if we rebase, we're really not changing anything as far as the amount of money that we spend. We're spending the same amount of money. The only difference is that we're being honest about how much money we're spending.

The previous system of going to the end of the year and then having this dance that we did every year is actually gimmickry. It's trying to pretend that we're spending less money than we are. So at least let's have some transparency and rebase and predict the true cost of the medical care that we're providing to our seniors and disabled. That's where we need to start.

I would also say that there are a lot of imaginative and innovative ways that people are discussing about physician payment, and we're not opposed to any of them. We're interested in trying to find the right solution and the right way to do it and we're hopeful that we'll be successful in that. But the first thing we have to do is rebase. That's absolute necessity because otherwise it looks expensive to change the SGR when in truth it doesn't cost any more than if we didn't rebase. It's the same price that we're all paying.

Ms. KIRKPATRICK. Thank you. One of the things that I've noticed over the years is the increasing complexity of the reimbursement process and since we're talking specifically today about Medicare, I'd like to hear from Dr. Harris and also you, Mr. Hannon, from your standpoint. If you think that reducing that complexity somehow streamlining the reimbursement process might actually help deliver better healthcare, and provide a better cost basis.

Dr. Harris, we'll start with you.

Dr. HARRIS. As you know, we favor eliminating the SGR, but we feel that certainly a need, Congresswoman Kirkpatrick, for payment reform. Now the model that is talked about most now is the patient-centered medical home. First, we would suggest that it be expanded from simply the eight states to convert it from a demonstration project to a pilot project. It will be much more meaningful data if it involves far more than the 400 physicians that are anticipated to be involved. That's number one.

Number two, that we need to explore other models. I mean no one knows the answer to your question how best to do this. But we need to get on with trying other ideas. So we would encourage this Committee. We would hope that you would encourage that HHS would have the authority to test other models so we could see which accomplishes what you're after.

Lastly, to the issue of simplifying things, everyone would applaud that. I mean with hundreds of insurance companies, no two doing things similarly, it just takes enormous numbers of personnel just to keep this huge ship afloat. We believe that the patient-centered medical home though holds promise for simplifying that. And that if there is some component of reimbursements that's based upon bundling as in for a team-based approach where physicians and for the payor they know that there is a bundled payment. They're not looking as much for cause for pre-certification or to jus-

tify because they don't really care. That would make it much easier.

Ms. KIRKPATRICK. I realize I've exceeded my time, Madam Chairwoman. I welcome your response in writing. I don't want to take any more of the Committee time, but thank you very, very much.

Chairwoman VELÁZQUEZ. Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Madam Chair. I think Dr. Moffit hit it a while ago when he said the devil is in the details. I think one of the things you're trying to do today is how a small provider is being impacted by what's going on and until we know a little more in detail about what's going on with the budget, we're kind of throwing darts with a blindfold on here, I think. It's difficult to get our hands around this issue.

I certainly appreciate all of you being here today and giving us your concerns and your input because within the day we have the finest healthcare system in the world. We've got to find a way to keep it in place and be able to pay for it. That's our struggle.

I just have one quick question. Just to follow up on Mr. Graves' initial question about the IT stuff. In talking with some of my doctors --and this is directed at Mr. Heyman here when he made the statement-- it saves money and it's easier to access and do things. The doctors in my District—I've got one large practice or a large group of them-- and they're telling me that most of them that do it have found it rather cumbersome from the standpoint of it takes time and the longer it takes to do this, the fewer patients they see; therefore, in essence, it doesn't necessarily save a lot of money from the position that obviously the fewer patients they see, the less money they make. So can you address that? Are they wrong or so we just got a learning curve here, we're not up to speed? What are your thoughts?

Dr. HEYMAN. I think you just hit it on the head. It is a learning curve. There's no question about it. In my first two weeks of doing this, I was seeing one patient every hour just so that I could learn this system. There's no question that there's a learning curve. But after you're familiar with the software that you're using, and almost all of the really good software is the same way, once you're familiar with it it becomes very, very easy to just—it's like talking almost or typing. You just get used to it. But it takes a while. There's no question about it.

And the other problem for a practice like you described, is that it isn't just in my case because I'm using it I have only a single employee, so I have only one person I have to teach. In the practice you're describing, they not only have to teach all of the physicians, and all of the ancillary people that are actually providing the care, but on top of that they have to teach everybody in their practice how to use this thing. And it slows everybody down. It's not just the provider, it slows everybody down when you first start using it.

So I would agree with them.

I'll tell you another barrier is that people know that eventually they're supposed to talk with each other, all these different software products. And a lot of people feel that they're not talking to each other now, so maybe it's a good idea to wait until they are talking to each other and that they know that they have the final

version. I don't happen to agree with that, but I sure understand that. If it were me, today, and I were in that situation and I didn't know about the software, all of these major products will eventually talk to each other.

But I would be holding back myself.

Mr. LUETKEMEYER. I think you've got another point that I was going to get to shortly also with regards to being able to integrate the different software programs because I know even within some of the hospitals that I've been talking to you have different areas of the hospital that can't even talk to each other because their software programs don't connect. That is a tremendous inefficiency within the hospital itself. So it's a huge barrier for care. It's a huge barrier for being able to do the kind of job that they're really supposed to be doing.

I guess my comment would be, ″how do we get past that?″ I know with the advances in software, you're going to continually, in my business world back home, we have new software changes every three years. We just rotate one in and rotate the other one out after three years. I mean, if this is the case here, how do we keep up? You're talking about a long learning curve here. Are we going to be that inefficient from now on?

Dr. HEYMAN. I believe that it will increase efficiency. I believe that any physician that does this, once they've been doing it for a while they would never go back to paper.

Mr. LUETKEMEYER. Dr. Preskitt, you've got your hand up there?

Dr. PRESKITT. Yes, thank you very much. I agree with Dr. Heyman. Just for disclosure, I don't have an electronic medical record. I am in a group that is looking at them for primary care. That may be why you sat me next to him, but health information technology is extremely important for surgical practices because we rely on hospitals and hospitals rely on us. Most of what we do is done in a hospital. And any health information technology I have in my office must speak to the hospital system, be able to relay information as well as radiology results and x-rays. So the interrelation not just between hospitals and small business practices, but between these practices and the hospital systems until it does that, it probably won't be worth the expenditure.

Mr. LUETKEMEYER. Thank you. Thank you, Madam Chair. I yield back the balance of my time.

Chairwoman VELÁZQUEZ. Mr. Sestak.

Mr. SESTAK. Thank you, Madam Chair. May I ask just a question of Dr. Moffit? You had, in your testimony, you had been open to the issue of I think pay-for-performance and hospital readmissions, the policies, how well it's done it seems to be what your question is.

On the hospital readmission, in President Obama's budget there seems like there's both the carrot and the stick. It isn't just a stick and I'd appreciate it, sir, if you could comment upon this because your testimony indicated there was more of a stick there rather than any carrot.

So how would you construct it to make sure, sir, if it was done well? He kind of bundles his payment with the 30-day afterwards with acute provider, so there's a little carrot there and a little stick

with a little less payment if they have to come back. What would you do to make sure this works?

Dr. MOFFIT. I'm not certain. I am not certain. I like—

Mr. SESTAK. You're not opposed to the idea. You're just not certain how to execute it?

Dr. MOFFIT. No, as I said in my testimony, I think the objectives of this are very, very good.

Mr. SESTAK. Does a proposal of comparative research help in this area?

Dr. MOFFIT. It might. Well, comparative effectiveness focuses primarily on medical treatments. The President is addressing what is probably one of the weakest links in the American healthcare system: the sickness or spells of illness that happen to the elderly where they end up in hospital intensive care units, usually for a week or two. They're there for a while. Oftentimes, there's a great deal of confusion. You have the young people coming to see their parent and they're trying to find out exactly what their medical situation is. They're there for a spell of time and then they're sent from the hospital emergency room or from the intensive care unit to some skilled nursing facility.

Mr. SESTAK. Right.

Dr. MOFFIT. And they're there for a while, I'm afraid too often, there's a breakdown in the continuity of care. And they're there for a while and then they're sent back to the hospital. Clearly the President's objective here is exactly right.

Mr. SESTAK. He's got the right idea.

Dr. MOFFIT. Yes.

Mr. SESTAK. It's not dissimilar to a Vet getting out of the Department of Defense and trying to find his way through the VA.

Dr. MOFFIT. Right.

Mr. SESTAK. I'm quite taken, if I could, and ask you, sir, how might you do it. You were a little more concerned, I think, that you're going to get a little less cost if it comes back to you to pay. The reason I am is the question that's come up here several times is how do pay for all this?

Dr. MOFFIT. Right.

Mr. SESTAK. And every research that I've done, the way we pay for this is efforts like yours, Doctor, the preventive care if you really do go to these patient-centered medical homes. If the savings that they can bode or the savings that we can get out of this pay-for-performance or how we do it, that in my mind is the real pay, almost simultaneously we need to do HIT and other things.

Do you disagree with that approach?

Dr. MOFFIT. No, no.

Mr. SESTAK. Sir, how would you do this?

Dr. MOFFIT. I think there are two things here. Pay-for-performance is a separate issue, I think, from the hospital admission issue. Physician pay-for-performance is a separate issue. But I like in principle the idea of ″bundling the payment″ to the hospital for spells of illness in certain cases. I think if we start paying for results that is where we ought to go.

Mr. SESTAK. I agree. I need to move over. Results in the terms—

Dr. MOFFIT. Results in terms of outcomes.

Mr. SESTAK. Preventive care.

Dr. MOFFIT. Not just preventive care. When we have people in the emergency room, when we have people in the intensive care unit, we don't want them to be ″frequent flyers″ from the skilled nursing facilities back to the hospital.

Mr. SESTAK. I understand. If I could just move—and I know that you're a special case in the sense that your data is less and that, but how would you set this very important critical area up?

Mr. HANNON. Certainly hospitals look forward to doing the bundling.

Mr. SESTAK. Less data because hospital—

Mr. HANNON. Our concern is oftentimes as you look at the path of treatment for patients, especially in rural communities, it may start in a physician's office, come to a hospital for a part of the admission, and for diagnostic testing, and then get transferred to another facility to have some level of care performed and then the patient or their family requests that that patient be moved back to the rural community to be closer to home.

And so as we bundle that, how are we going to come up with the proper way in which to make sure that all of the parties who are taking care of the patient are properly paid? In rural communities, more often have limited number of partners in which to pair with. For instance, in our community, there are only three home health agencies, only one of which takes Medicare patients today and only one of which has a physical therapist as a part of that home health agency.

So as we bundle care, and that patient needs to go to home and that care is bundled under that payment, there may be some delay in getting care to that patient because of the limited resources in rural communities. And so that is the concern. It's not that we're opposed to it. It is that we want to make sure that it is done fairly and appropriately.

Mr. SESTAK. I've run over my time. Thank you.

Chairwoman VELÁZQUEZ. Mr. Thompson.

Mr. THOMPSON. Thank you. Having just come out of rural health for the past 28 years and in the Fifth Congressional District of Pennsylvania which is the most rural District in Pennsylvania, we have lots of hospitals, small hospitals, some healthcare providers, rural access hospitals. This is a very important issue and certainly my public policy involvement came out of the fact that we have a healthcare system today that's built on regulations from 50 years ago, many of them, which is probably step one with healthcare reform, bringing the regulations into the 21st century.

Mr. Hannon, first question, we're talking about the President's budget, Medicare impact and small providers. Many hospitals in my experience and some of you concur, and healthcare agencies rely on charitable contributions for investment and capital expenditures, new equipment, diagnostic equipment, sometimes treatment intervention equipment and that's driven through charitable contributions. And any thoughts on how the President's proposal to eliminate the charitable tax deduction for some taxpayers may impact that?

Mr. HANNON. Thank you for the question. While I haven't studied that with the American Hospital Association, I am certainly very concerned about that. Having come out of Pennsylvania my-

self prior to going to North Carolina, a great deal of how we survive, how we grew, how we provided technology was through philanthropy. Even today as we look in North Carolina, for example, with the economic times that we are in, we've already been told by some of those philanthropic organizations that we're likely to have less opportunity and a greater competition for the few dollars that are going to be available to us. Their contributions are down in those agencies and therefore their ability to hand that money to hospitals is also down.

We used to rely on it and I'm sure many of my colleagues across the country would agree that we can sustain our day-to-day operations from the revenue that we get from patient care. The ability to expand, the ability to bring new technology, the ability to replace our aging plants is really done by those contributions.

Mr. THOMPSON. Thank you. I want to take that tax proposal within the budget next step to kind of open this up to all those who are representing the physician providers just to see what do you see as the impact on small healthcare providers, specifically those physicians whose practices may be organized as LLCs or S Corporations with a proposed, the President's proposed tax increase rate for those who are in that $200,000 or $250,000 and higher?

Dr. HARRIS. I confess I don't know enough to answer your question about the tax code and so forth. I couldn't give you a meaningful answer.

Mr. THOMPSON. Any thoughts? I certainly encourage you to go back and take a look at that in terms of those physicians that you have that are organized in those ways that they are going to be impacted pretty significantly, perhaps, by that.

Next question, actually back to Mr. Hannon, I know one of the things in rural—it's good to hear you came from Pennsylvania. Sorry you left. In rural Pennsylvania, one of the issues that I hear all the time and I experienced myself had to do with the Medicare wage index and how that drives reimbursements. And in terms of the differences, how does the wage index in your opinion, the wage index payment system impact rural providers versus urban providers? Any opinion on that?

Mr. HANNON. I do have an opinion on that. I have found that over the years, and most of my career has been in rural healthcare, that as the rural communities, especially those adjacent to more metropolitan areas are competing for that labor force, we're at a significant disadvantage. We can't compete with the wages of our urban counterparts. It is harder for us. We all compete for labor. There is a shortage of labor. There's no question about that, whether it be x-ray technicians or nurses or physicians. As we recruit, it is much harder for us with that wage index formula.

Mr. THOMPSON. Okay, great. I have just a short time left, but I throw one question out that really I don't think has been addressed. The looming crisis in healthcare, as I see and experience is the lack of qualified physicians, nursing and allied health as a result of the baby boomer retirements, specifically, especially in rural America. Any thoughts what the impact of this will be, not just fiscally on our healthcare, but certainly from a workforce perspective on those that you may represent?

Mr. HANNON. I'll be happy to start. We have 420 employees, 311 full time employees. Seventy of my employees, 70 of the 400 are over the age of 60 this year. We will have a significant problem trying to recruit technicians, especially, to that area. As we look at recruitment of physicians to our community we are finding that the group of physicians that we're able to recruit to our community are actually those who are nearing retirement, because those coming out of residency are not interested in coming to rural parts of the country.

Dr. PRESKITT. Thank you very much. There's no question, general surgical workforce is aging as all health professionals are. Twenty years ago, 39 percent of general surgeons were in the 50 to 62 year of age group. Now it's 50 percent. Now don't get me wrong. I think that's a very blessed age group to be in. Frankly, these surgeons and physicians are probably at their prime, but they are looking for that.

We are finding that folks are retiring earlier. However, this recent economic change may change that. I think one of the key things is the assistance with graduate medical education. I had a young partner who moved to the suburbs. He had $150,000 of medical school loans to pay back and that's about what a house would cost when you're starting out. When I graduated from medical school in '75, that's 1975—

Chairwoman VELÁZQUEZ. We have an opportunity with other members. You will have an opportunity to expand. Time is expired.

Dr. PRESKITT. Thank you very much.

Chairwoman VELÁZQUEZ. Mr. Ellsworth.

Mr. ELLSWORTH. Thank you, Madam Chair. We could be holding these meetings every day until we fix this problem and the Committees definitely should.

Dr. Moffit, I appreciate your comments. I don't disagree at all with you about naming the price first and in a former life, we built a building in my county. They put a $35 million price tag on it and you guess how much it cost? Right at $35 million. So I agree with you.

Dr. Harris, what I heard you say in a more eloquent way is that for the first time in a long time, President Obama was being honest about what the cost is and that these things belong in the budget and no different than the war in Iraq and Afghanistan ought to be in the budget and people ought to know.

I heard a Member say one time that sure, our budget is smoke and mirrors, but it's a hell of a lot more honest of smoke and mirrors than their side. That's not what the American people expect and it's not what they want us doing here.

I think we can stipulate that this system needs an overhaul. I think everybody at the table has said that already. What I see in my short time here in Congress is the different groups come in and many of those at your table come into our offices and talk about what your particular organization or alliance needs for their portion. And what we're not getting is I'll get some groups come in, they'll beat up on the HMOs and the insurance companies. The insurance companies come in and beat up on the docs, the hospitals, doc-owned hospitals beat up on the hospital association and vice versa.

We're going to have to throw everybody in the same room at the same time. We don't do this stuff for a living like you do. You know this stuff. We make the rules based on your suggestions, and all have very convincing arguments. I think we have to all get together.

One, can we do this one spoke at a time, or is it going to have to be a comprehensive healthcare reform, everybody in the room, lock everybody in until we come out with a finished product? Or can we do it a spoke at a time so we don't keep kicking this can down the road and just take a yes or no if we can do that, because I have a couple of other questions.

Can we do it comprehensive? Or is it going to be a spoke at a time? What do you see?

Dr. MOFFIT. I don't think that you can pass a comprehensive bill. I don't think that Congress has the political machinery to do that, and maintain the kind of consensus you will need to make it work. I think this is one area where Americans, as I pointed out, have a broad agreement on the goals. I don't know of any person that I deal with in the healthcare policy community that thinks that all Americans should not have health insurance coverage. I don't know anybody who feels that way.

I don't know anybody who thinks that we should not control costs in an efficient way or improve the value that we get from the dollars that we're spending on this $2.4 trillion system. But when you get into the details that is where the consensus breaks down. I'm not trying to rain on this parade. All I am saying is that this process, if it is really going to work, is going to have to be a process where we work together. It has to be bipartisan-a real bipartisan process- of coming to agreement on this. And we've got to focus in on those matters that we can all agree on.

There are two areas where I don't think there is much debate. One is that low-income people who do not have access to health insurance, access to private health insurance, ought to get some direct assistance in getting it. That is one clear area where I think Republicans and Democrats agree. The other thing to remember is that the United States is a country of 300 million people in very different states where the healthcare systems actually differ a great deal. The health insurance markets in Massachusetts and the health insurance markets in Utah are not the same. And we have to recognize therefore that we're dealing with a very diverse thing. It's not one single system. So we have to be careful. I think we have to move discretely, and we have to debate every provision. This is not to slow things up. It's just to make sure that we understand what we are doing because this is an area where the law of unintended consequences can go berserk.

Mr. ELLSWORTH. Mr. Hannon?

Mr. HANNON. Mr. Thompson, I would say the simple answer, yes, I agree with you that we do need to get together, and in fact, there is a group meeting together of all of the players here at the table and well beyond in an effort to bring health for life to this community. AHA is a member of that effort as are the other members who are here at this panel and many more who are coming together to fix this issue. We do believe in the healthcare reform and it's important.

Mr. ELLSWORTH. Dr. Harris?

Dr. HARRIS. Mr. Ellsworth, we need a major overhaul of the healthcare delivery system in this country and it will require all the stakeholders. The reality of it is everyone is going to have to give up something to make this system work.

Mr. ELLSWORTH. Ten seconds? Thank you. Like you said, I think you're right, Dr. Moffit, we're going to have to compare apples to apples on these policies, what coverage people get and we have to look at end of life issues, what's the percentage, is it 68 percent, I've heard, in the last two weeks of life, nobody wants to talk about it, but you all may have a statistic that I haven't heard that 68 percent of healthcare cost is spent in the last two weeks of life. Is that accurate? Okay, okay. Thank you very much. I yield back, Madam Chair.

Chairwoman VELÁZQUEZ. Ms. Dahlkemper.

Ms. DAHLKEMPER. Thank you, Madam Chair. I come out of a healthcare background. I was a dietician for 24 years, so this is always great for me to hear all of you out there that I have worked with so many of you over the years.

I am also from Pennsylvania. I actually—my District borders Mr. Thompson's District and we have very similar issues when it comes to rural healthcare. Most of the hospitals in my District are really in much more rural areas and even the ones in the most urban area deal with the wage index. I'm like Mr. Ellsworth, being lobbied by every single group and the issues do differ, so I thank you, Mr. Ellsworth, for bringing up your point. I think it's a great point to make.

As we go forward here, we've got to put everybody in the room and we've got to come to consensus and there's got to be give and take.

I did have a question, Mr. Hannon, for you regarding the bundling issue and particularly small rural hospitals because as I've looked at this, I see this as such a challenge and I think maybe it's because of my current experience, my 80-year-old parents and the issues they've had over the past few years. And just looking at this goal to reduce healthcare costs and when you are in a more rural area or an area even as I am in Pennsylvania where many people will go to Cleveland and Pittsburgh to have their other procedures done or continued healthcare done.

What can you give me as specific examples of the types of challenges that you think that hospitals are going to face as we look forward to this? And it kind of goes back to, I guess, Mr. Sestak, and we have to have a model for this.

Mr. HANNON. Right. I think some of the challenges that we will face is different in every community. The resources, in particular, in rural America are different from those in our urban areas. As I mentioned, we're blessed to we have three home health agencies in my community, but only one takes Medicare patients. So if we're going to be bundling and we're going to be looking for partners where we can come together to provide the most efficient, cost-effective care, how will we measure that? What are our choices?

In our community, getting access to assisted living facilities is often the challenge. Patients in rural communities may complete their care in a hospital and we wait to find an available bed in a

skilled nursing facility. That doesn't help us reduce the cost of healthcare in those areas. Those are some of the challenges that we have.

So much of healthcare also involves mental health coverage. In rural communities, the limited number of mental health providers and the social workers, to assist the family with the challenges of taking care of especially an elderly person, a tremendous weight on the hospital. We are looked to as the source for that care when we ourselves don't have those resources.

Ms. DAHLKEMPER. I guess I would like to hear from any of your physicians' organizations regarding the bundling issue and where you see the challenges in terms of your specific groups?

Dr. PRESKITT. Well, from a surgical standpoint, risk adjustment and looking at those models, the NSQIP program we have uses 30-day risk-adjusted mortality. I think there are three of you from Pennsylvania. I've not heard the Geisinger system mentioned, but they've proven that with a model population where it's homogeneous, that in fact, you can develop statistics and data and figure out what it costs to provide care within a system. The Geisinger system, as I understand, also utilizes the advanced medical home.

I think done with proper data, bundling can occur that would involve surgical services within that 30-day period. Currently, we're personally bundled in a 90-day period for most of these cases.

Ms. DAHLKEMPER. Dr. Harris?

Dr. HARRIS. Yes. I noticed of bundling physician services with other physicians, with other hospitals, with hospitals, is among those options that we feel need to be studied more. And in truth, don't have enough data on to answer specifically how it would work.

The one bundling though that we believe there are good data on is bundling of service in that patient-centered medical home because the current payment system which as you know is based largely on a fee-for-service type of thing, the only thing that that uniformly achieves is that people are rewarded for seeing more patients or doing more procedures. So bundling is the notion that obviously you would like to fund a team, including nurse practitioners, PAs, dieticians, I mean people to help you by taking a portion of the load. We believe that's a much more effective way to reform the healthcare system, the financing of it.

Ms. DAHLKEMPER. Thank you. Dr. Heyman, did you have anything you wanted to—

Dr. HEYMAN. Well, I would just say if by bundling you mean combining physicians and payments with hospital payments, I find a certain irony there because when you're talking about accountable healthcare organizations, that kind of thing, on the one hand we hear of this tremendous resistance to physician-owned hospitals and yet on the other hand we're proposing all kinds of ways to make physicians and hospitals work together and have the same incentives and it doesn't make any sense to me that the same people are talking about both things. It seems to me that this is a great argument for physician-owned hospitals.

Ms. DAHLKEMPER. Thank you. My time is up.

Chairwoman VELÁZQUEZ. Mr. Griffith.

Mr. GRIFFITH. I thank the panel for being here and Dr. Harris, I think that with the shortness of time I think you've identified the problem, is the lack of primary care. I believe that we recognize that two percent of our classes are going into primary care and our primary care providers are aging and moving off the stage, so to speak.

The obvious to me is that why aren't we using our nurse practitioners, our PAs, more aggressively and why aren't we empowering them and each state to be our primary care providers because if we started today it would be a decade or maybe more even if we could incentivize the primary care provider to go into primary care, so to speak, and if we could incentivize them to be distributed properly, it would be a long time coming.

I believe that the American College and the AMA and the American College of Surgeons could go a long way as far as our healthcare problem is concerned, if we could identify the restrictions that are centuries old on what someone can do for a patient, whether it be order a mammogram or an x-ray or work up that patient. And the other thing that we're not saying is is that physicians are trained with an emergency room mentality. And we know that half of all of our deaths for the next century are going to be lifestyle-related deaths. And trained physicians are very poorly trained to take care of the young family, advise the mother on nutrition, walk through them a holistic type approach and I believe that that's where we're going to fall down as far as our obesity, diabetes, hypertension, neonatal care, and many of us from rural areas have seen this over and over and over again. And it appears that we're training these well-trained PAs, they're taking care of our men and women in Iraq right now. They're in every U.S. embassy, but yet we don't allow them to practice in the United States.

Dr. HARRIS. Mr. Griffith, the American College of Physicians couldn't agree with you more that we need a team-based approach to healthcare. And modeled again in the expansion of primary care with offices with a team of people including nurse practitioners and PAs.

We met with many of the leaders of the nurse practitioner organizations just last July to talk about how we could work collaboratively to try to improve the quality of healthcare. We just published a paper that said that we believe in the CMS demonstration projects, that they should also consider looking at nurse practitioner led medical homes. As you know, that's controversial, but the reason we did that is it would be utterly pragmatic. I think I'm right about this. Twenty-eight, if I have the number right, of the states, plus the District of Columbia, allow nurse practitioners to practice without physician supervision. And of the remainder that require physician supervision, only one requires that the physician be on the premises. Thus, it makes sense to look at that model.

Now the second part of your question about essentially scope of practice, that is defined by each state and it differs from state to state. We applaud the notion of people practicing within this scope of practice, but not exceeding it. We still believe that the best medical home is one headed by a physician, and particularly, particularly, with the chronically ill patients in this country. Twenty-three percent of every one on Medicare has five or more chronic illnesses.

We believe they certainly fit into the scope of practice of a well-trained physician, primary care physician.

Mr. GRIFFITH. Well, I appreciate that and I would say to Dr. Moffit that in every physician's exam rooms is a plaintiff's attorney, so if you're wondering why those patients are readmitted from a nursing home or an intermediate care facility, it's because the family is there and the physician is there and he is basically saying to himself, I really don't have a choice. I know I shouldn't readmit, the patient is terminal, but there's the plaintiff's attorney lurking there somewhere. I think that is an issue that we haven't discussed, but has to be addressed.

Dr. MOFFIT. There's a good case for medical malpractice reform.

Chairwoman VELÁZQUEZ. Time has expired. Ms. Clarke.

Ms. CLARKE. Thank you very much, Madam Chairwoman and Ranking Member Graves for holding this hearing today on a topic that is so critical to my District, and indeed, to our nation. As Congress works to finalize the FY 2010 budget, we must closely examine Medicare, Medicaid. The Obama Administration proposes changes to these programs that may impact small healthcare providers and the success of healthcare reform.

Medicare/Medicaid are nationwide programs that provide healthcare coverage for over 43 million elderly and disabled Americans. These programs, particularly Medicaid, is vital to many low-income New Yorkers—I'm a New Yorker—who rely on this program for primary care. The examination of the President's budget proposal and how it may impact small healthcare providers is an imperative for the success of our emerging healthcare delivery system and the growth of its economic viability within our local communities.

My first question is to Dr. Harris. You stated in your testimony that the Institute of Medicine reported that the additional primary care physicians are—that additional primary care physicians are now needed to meet the demand in currently undeserved areas. I just learned that in total over 1.9 million Medicare enrollees currently live in areas with inadequate access to primary care physicians including Flatbush, Brooklyn which is located in my District.

As a matter of public policy, what do you think that Congress should consider to address the currently underlying shortage in available primary care resources and what could we do to attract these physicians to undeserved areas?

Dr. HARRIS. Madam Clarke, as you suggest, there is a shortage now, even with 46 million uninsured people, we're 16,000 short, according to the Institute of Medicine and the Health Affairs projects it's going to be a 40,000 shortage, that's even allowing for the nursing issue. So it is an enormous issue.

I think two things come to mind. One, part of the patient-centered medical home demonstration projects has to do with Medicaid. As I recall, there are 25 states in the United States which are now trying Medicaid demonstration projects to see if the patient-centered medical home concept can help reduce the cost and improve the quality for those who are on Medicaid in those 25 states.

The second issue gets to your point of the distribution of physicians. A very difficult issue. I mean the practical one that one can

do now, we understand that Congresswoman Allyson Schwartz, I believe, is introducing legislation that will propose loan forgiveness for kids of about $30,000, $35,000 a year to help overcome their debts from medical school in exchange for time that they will spend in undeserved areas.

What the College would say and encourage you is when you're defining these undeserved areas, think about primary care in undeserved areas, not all physicians because that truly, as your District is where the need is so utterly acute.

Ms. CLARKE. Can you, Dr. Harris, can you determine how primary care physician availability may be affected by possible hospital closures? Do you know if most area hospitals can accommodate displaced ambulatory care resulting from a reduction in primary care?

Dr. HARRIS. No, I mean you would have two dreadful things happening simultaneously. You would have a shortage of the primary care physicians who ostensibly could follow people in an outpatient setting and provide preventive care, their acute illnesses, their long-term chronic care.

Then you would have the hospitals to which many of them now turn, absent primary care physician, particularly for the acute care. So it would simply compound the problem, but you know, at the risk of beating a dead horse, we believe therate limiting factor and if I can add, if I may, for the Committee just parenthetically, the American College of Physicians championing this notion of primary care is not as self-serving as it sounds. Half of our membership is subspecialists. This is a difficult message we have to convey to them. But we have tried to do it in an objective fashion and the data again, in this country and overseas, utterly compelling, that the best way to reduce costs and improve quality coast to coast is trying to get our 30 percent of that workforce up closer to the 50 percent as all those other 12 countries have which have everything so much less expensively than we do and with better outcomes than we do.

Ms. CLARKE. Thank you very much, Madam Chair. Thank you to all of you for your testimony today. It's been quite compelling and I'm sure we'll be relying on your expertise going forward as we look at what we do with our healthcare system for the 21st century. Thank you very much, gentlemen.

Chairwoman VELÁZQUEZ. Mr. Thompson, do you have any other questions?

Mr. THOMPSON. First of all, I thank the Chairwoman for this. This is—more dialogues like this, the better. I want to thank my colleagues, Mr. Griffith, Ms. Clarke by following up on the workforce issues. This is about, a lot about access of healthcare. We're all concerned with access, affordability and quality. But we can't have access when we don't have qualified providers out there. So the fact that we've gone down that road, I appreciate your responses. If we don't have qualified providers, it doesn't matter what the reimbursement system is. It doesn't matter how we're structured and so the supply side of healthcare is something we need to attend to as well. So I just appreciate the panel's expertise and input this afternoon. Thank you.

Chairwoman VELÁZQUEZ. Thank you, Mr. Thompson. I want to take this opportunity to thank all of you for being here today, for being part of this discussion. I just want to make sure that small businesses are represented at the table because a lot of medical solo practitioners are small businesses and given the challenges that we face in terms of healthcare costs, our budget, the fact that 47 million are uninsured without any type of health coverage in the richest country in the world, inaction is not an option.

I feel very optimistic that we're going to get it done, but we have got to do it right and that is why it's so important to continue this type of discussion until we have a bipartisan comprehensive legislation that truly addresses the most dramatic issue of the rights of healthcare costs and the fact that still so many do not have access to quality healthcare coverage, including our children. So with that, I thank you all and I ask unanimous consent that Members will have five days to submit a statement and supportive materials for the record. Without objection, so ordered. This hearing is now adjourned.

[Whereupon, at 2:59 p.m., the hearing was adjourned.]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

SAM GRAVES, MISSOURI
RANKING MEMBER

Congress of the United States
U.S. House of Representatives
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515-6315

STATEMENT
Of the Honorable Nydia M. Velazquez, Chairwoman
United States House of Representatives, Committee on Small Business
Full Committee Hearing on: *"The President's FY 2010 Budget and Medicare: How Will Small Providers be Impacted?"*
Wednesday, March 18, 2009

In the last few years, this committee has heard from countless entrepreneurs who say healthcare costs are crippling their businesses. For many small firms, rising premiums have become a barrier to growth and success. So it was not surprising when the President used his February speech on the budget to make the case for reform. As he later put it at the White House Healthcare forum, "the greatest threat to our nation's balance sheet is the skyrocketing cost of healthcare."

As part of its budget for the coming year, the new Administration has made healthcare reform a top priority. And with good reason. The current system is bankrupting businesses and costing our country $2.4 trillion a year. On a per capita basis, Americans spend 250 percent *more* than any other advanced nation. Clearly, the system is broken, and we cannot continue down this path.

For decades, this country has been waiting for comprehensive healthcare reform. Now that it is finally becoming a reality, we are going to see some very real changes in the system, especially for small businesses. This afternoon, we will review many of those proposals, and hear from the individuals who will be handling them day in and day out. Their views should give us the insight we need to start determining next steps.

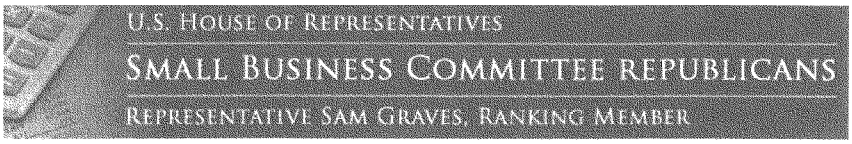
Healthcare reform affects entrepreneurs on many levels. To begin, it helps ease the burden of rising insurance costs, which have jumped 129 percent in the last eight years. With premiums growing four times faster than wages, the need for change has never been greater.

Small medical providers -- who are the core of our healthcare system -- will also have a critical role in reform efforts. Small businesses make up nearly 70 percent of all healthcare practices, and they recognize that the current system is simply not working. These are the entrepreneurs who will be implementing change, and they are the people spearheading the process.

A key component of reform is an increased emphasis on efficiency. That includes streamlining the system and modernizing it through a greater use of Health IT. Additionally, it means cutting expenditures such as Medicare overpayments and hospital readmissions. As a result of these measures, Americans should see an estimated $316 billion in savings. Those savings will go a long way in ensuring that every American has access to quality, affordable coverage.

The budget provides a clear outline for reform. However, President Obama has said he is not rigid in those plans, and welcomes innovative ideas from all around the country. After all, our healthcare system touches the lives of every single American. Rather than taking a one-size-fits-all approach, reform should account for a broad range of interests. This is particularly true when it comes to the unique needs of entrepreneurs.

Like all other business owners, the providers here today are stakeholders in the movement towards greater healthcare coverage. They are also the men and women in the trenches, making sure that the system works for everyone. Their input will be an invaluable asset to the reform process, and I look forward to hearing their suggestions for next steps.



Opening Statement of
Ranking Member Sam Graves
House Committee on Small Business
Hearing: "The President's Budget and Medicare:
How Will Small Providers be Impacted?"
March 18, 2009

Madam Chairwoman, thank you for holding this hearing on the changes to Medicare that are proposed in President Obama's Fiscal Year 2010 budget. I'd like to extend a special welcome to our panel of witnesses, who have particular expertise in health care reform, for being with us today. We look forward to your testimony.

We are a nation that is certainly concerned about health care. 45 million Americans are without health insurance. For those who do have insurance, and can afford to pay the premiums, the costs are rising. And for small businesses, the problem is even more challenging: how to operate a small company in a worsening economy, while continuing to attract and retain the best employees, which means offering competitive salary and benefits.

The health care budget that President Obama presented to Congress is remarkably lacking in detail. And as we know, the devil is always in the details.

Small businesses are committed to offering health care to their employees. But many are concerned about proposals in the President's budget. The budget recommends spending $634 billion over the next 10 years to create a Reserve Fund to help finance health care reform, although some estimate the cost of universal coverage and other reforms could reach $1.2 trillion.

That $634 billion reserve fund comes from several sources. First, it comes from raising taxes on individuals earning more than $200,000 per year and couples earning more than $250,000 per year; many of whom are small business owners, and who tend to return any profit back to the business. Second, it comes from cuts or changes to Medicare or Medicaid payments. But even the budget itself notes that this sum will be insufficient to accomplish health care reform, and is a mere "down payment." Exactly how much more will be needed, and the source of these additional funds, is not disclosed.

To its credit, President Obama's health care budget recognizes the significant problem with unsustainable growth in entitlement spending. However, the budget also includes an enormous expansion of costly entitlement programs. This is at a time when spending levels on our current entitlement programs, such as Medicare and Medicaid, are simply unsustainable.

Small business issues are non-partisan. We can all support strengthening America's small companies, which are the job creators of our economy. We can all support the goals of increasing access to affordable health insurance and increasing the quality of outcomes. We must also, however, ensure that America's small business owners have the tools they need to grow and lead our nation's economic recovery, and are not unfairly burdened with additional taxes, mandates or regulations.

Again, thank you, Madam Chairwoman, for calling this hearing. I yield back the balance of my time.

STATEMENT

of the

American Medical Association

Committee on Small Business
United States House of Representatives

RE: The President's Budget and Medicare: How Will Small Providers be Impacted?

Presented by: Joseph M. Heyman, MD

March 18, 2009

Division of Legislative Counsel
202 789-7426

STATEMENT

of the

American Medical Association

Committee on Small Business
United States House of Representatives

RE: The President's Budget and Medicare: How Will Small Providers be Impacted?

Presented by: Joseph M. Heyman, MD

March 18, 2009

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on "The President's Budget and Medicare: How Will Small Providers be Impacted?"

We commend you, Chairwoman Velazquez, Ranking Member Graves, and Members of the Committee for holding this hearing. The AMA welcomes the opportunity to provide our views on the President's budget and its impact on physicians, as small businesses, and the patients they treat.

We greatly appreciate that the Administration's budget assumes a new baseline (a "baseline" is a forecast of projected spending over a period of time) for Medicare physician payment updates. This is known as "rebasing." Unlike previous budget forecasts, the Administration's new budget baseline recognizes that Congress needs to and will act to avert the serious access crisis that looms as physicians face drastic payment cuts in the coming decade due to the failed Medicare physician payment formula (the sustainable growth rate, or SGR). **The AMA strongly supports the use of a realistic baseline as a foundation for Congress to move forward with a permanent solution to the flawed SGR physician payment formula, and urges the Committee and Congress to ensure that a new Medicare physician payment baseline is adopted in the 2010 Fiscal Year (FY) Budget Resolution.**

The vast majority of physician practices are small businesses. Steep payment cuts under the SGR, along with numerous other challenges in the current health care environment, threaten the continued viability of these practices. Physicians are the foundation of our health care system, and thus it is critical that Congress address these challenges to ensure the continued delivery of quality health care in our country. "Rebasing" would strongly support this

foundation and pave the way for Medicare to fulfill its promise of high quality, cost effective health care to seniors and disabled persons, especially as Medicare prepares to begin enrolling the first wave of baby boomers in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016.

THE MEDICARE PHYSICIAN PAYMENT FORMULA IS FATALLY FLAWED

Medicare payment rates for physicians' services are updated annually on the basis of the SGR, a formula that has continually resulted in steep Medicare physician payment cuts. The SGR formula sets a target and if Medicare spending on physicians' services exceeds this target, physician payment rates are cut. These cuts occur even though the SGR target is linked to factors that do not correlate to medical practice cost inflation and does not make allowances for advances in medicine, such as new technology and shifts in care from hospitals to physician offices, that produce savings for the Medicare program as a whole even though they may increase utilization and the cost of Medicare physicians' services.

As a result of the flawed SGR, Congress has repeatedly had to scramble at the 11th hour to forestall steep cuts in Medicare physician payment rates. Despite these interventions, physicians face cumulative cuts of over 40 percent in the coming decade, including a 21 percent cut scheduled for January 1, 2010. Physicians cannot absorb these steep losses, especially when physician practice costs are expected to increase by at least 20 percent at the same time rates are being cut, and data released by the Centers for Medicare and Medicaid Services (CMS) show that, even before these cuts, physicians are only being reimbursed for two-thirds of the labor, supply, and equipment costs that go into each physician service.

These steep cuts would be unsustainable for any business, especially small businesses such as physician practices. Further, once Medicare cuts its rates, it has a ripple effect on patients covered by other payers that tie their rates to Medicare (including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs).

ADOPTING A NEW MEDICARE PHYSICIAN PAYMENT BASELINE STRONGLY SUPPORTS THE FOUNDATION OF MEDICARE

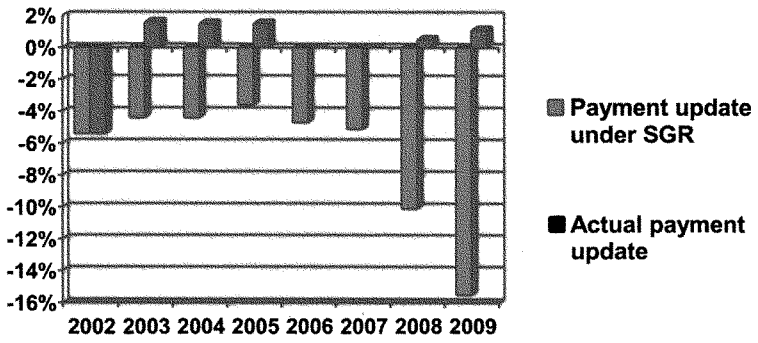
Adopting a New Medicare Physician Payment Baseline is a Realistic, Transparent Approach to Addressing Health Care Costs

As discussed above, the AMA strongly supports the assumption of a new physician payment baseline in the Administration's budget. The primary purpose of a baseline is to provide policymakers with a clear forecast of projected spending and taxpayer obligations. In previous years, forecasts of Medicare physician spending have been based on inaccurate assumptions. For example, each year since 2004, the annual reports of the Medicare Trustees have warned that their projections of Medicare's Supplementary Medical Insurance Trust Fund were "unrealistically low" because they incorporated an assumption that the 40 percent in physician cuts would occur. In actuality, since 2003, Congress has interceded six times to legislatively ignore the physician payment baseline and provide temporary payment increases.

In contrast to the Trustees Reports, the Administration's budget assumes a realistic assumption that Congress will continue to act to preserve seniors' access to care by stopping cuts produced by the SGR. This "rebasing," if also adopted by Congress in its budget resolution, would recognize the reality of future Medicare spending on physicians' services. **We urge the Committee and Congress to support action by the House Budget Committee to adopt a similar "rebasing" provision in its FY 2010 Budget Resolution by establishing a new baseline for Medicare physician payment.** Enacting legislation would be scored against the Budget Committee's new baseline, and this legislation could then repeal the SGR with little or no legislative cost (as long as spending in the legislation is in line with the baseline established in the Budget Resolution). If Congress does not establish a new baseline in the FY 2010 Budget Resolution, then hundreds of billions of dollars in offsets would need to be identified to pay for averting 40 percent cuts in Medicare payment rates.

"Rebasing" is a smart, realistic, and transparent approach to addressing rising health care costs because it allows accurate forecasts of what those costs are going to be. The chart below shows the actual Medicare physician payment updates between 2002 and 2009 (after Congressional intervention) compared to the scheduled payment cuts produced by the SGR for those years.

Physician Payment Updates Under the SGR
2002-2009



Because many of the legislative fixes indicated in the above chart were funded without adjustments to the Medicare physician payment baseline, Congress and the physician community now face a 21 percent cut in January 2010, along with steep cuts in the coming decade. To avert these future cuts that threaten patient access to care, Congress would have to intervene, thereby continually ignoring the current Medicare physician payment baseline. "Rebasing" recognizes this need for Congressional action year after year, and therefore more accurately reflects projected Medicare spending than the current baseline.

Adopting a New Medicare Physician Payment Baseline
Preserves Medicare Beneficiary Access to Health Care

Physician practices, as small businesses, cannot absorb the steep losses projected under the SGR, and numerous surveys project a crisis in patient access if Medicare physician payments fall further behind practice cost increases. For example, in an AMA survey, 60 percent of responding physicians said they would have had to limit the number of new Medicare patients they treat if the pay cuts scheduled for January and July 2008 had not been stopped. Further, more than half of the surveyed physicians said they could not have met their current payroll and would have been forced to reduce their staff. The Medicare Payment Advisory Commission (MedPAC) also reports that 30 percent of Medicare patients looking for a new primary care physician already have trouble finding one. Finally, the Medical Group Management Association found that 24 percent of group practices already limit their acceptance of new Medicare patients.

The projected cuts also affect the physician workforce. The Council on Graduate Medical Education is predicting the country will face a shortage of 85,000 physicians by 2020, and the Association of American Medical Colleges (AAMC) reported in November 2008 that there will be a shortage of at least 124,000 physicians by 2025 across all specialties. The current expansion of medical schools and growth in medical student enrollments will not address these physician shortages unless the number of U.S. residency slots increase as well.

Adopting a new Medicare physician payment baseline would help avert the SGR cuts and preserve access to care for Medicare beneficiaries. This, in turn, would favorably impact physician workforce concerns.

Adopting a New Medicare Physician Payment Baseline Allows the Health Care Community and Congress to Address Needed System-Wide Health Reform

Adopting a new Medicare physician payment baseline also is critical for achieving system-wide health reform. It would pave the way for establishment of a new Medicare physician payment system that accurately reflects increases in medical practice cost inflation. A stable, predictable payment system with positive physician updates will allow physicians and Congress to focus on other important issues that are critical for moving the delivery of health care into the new millennium. Since 2002, due to the continual threat of SGR cuts each year, physicians have been treading water simply trying to stay afloat and keep their doors open for business. This all-consuming cycle has precluded physicians and Congress from turning to other bigger picture priorities and reforms that are badly needed. Adopting a new baseline will mean that billions of dollars each year that are spent providing a temporary SGR fix would be available for other important reforms, including: expanding health insurance coverage for the uninsured; adoption of health information technology and electronic medical records, which will help facilitate participation in quality improvement and incentive programs; ensuring an adequate physician workforce; and investment in prevention and wellness programs that lead to a healthier nation and help control costs over the long-term.

Adopting a New Medicare Physician Payment Baseline Would Impact Millions of Employees, Patients, and Physicians Across the Country

Adopting a new Medicare physician payment baseline would set the stage to develop a new physician payment system that ensures positive payment updates that accurately reflect practice cost inflation. Physician practices, as small businesses, could then make business decisions, including personnel decisions, against the backdrop of a stable financial environment, without the continual threat a steep cuts under the SGR. This is critical, especially when considering that many employees may currently be at risk of losing their job due to Medicare physician payment updates that have fallen well behind medical practice cost inflation, on top of the struggling economy. **Thus, adopting a new baseline and averting physician payment cuts would bolster our struggling economy because it would help sustain the jobs of nearly three million individuals across the country employed by physicians and related businesses affected by the Medicare physician payment cuts. It would also benefit millions of patients and physicians across the country as well.** For example, if the projected 21 percent scheduled for January 1, 2010, goes into effect, this would produce a loss of $1.1 billion for the care of elderly and disabled patients in New York alone, and that loss increases to $17.1 billion by 2016 due to nearly a decade of projected cuts. Further, 177,520 employees, 2,582,471 Medicare patients, and 180,226 TRICARE patients in New York will be affected by these cuts. Missouri physicians will lose $260 million in 2010 due to the SGR cuts, and $4.1 billion by 2016. In addition, 53,769 employees, 869,941 Medicare patients, and 153,311 TRICARE patients in Missouri will be affected by the SGR cuts. A new physician payment baseline is critical for protecting these millions of employees, patients, and physician practices across the nation.

The AMA appreciates the opportunity to provide our views to the Committee on these critical matters affecting patients, employees, and physician practices, as small businesses, and we look forward to working with the Committee and Congress to adopt a new budget baseline for Medicare physician payments and preserve the delivery of high quality, cost-effective care for our nation's seniors and disabled patients.

American College of Physicians
Statement for the Record
House Committee on Small Business

The President's Budget and Medicare: How Will Small Providers be Impacted?"

March 18, 2009

Thank you, Chairwoman Velazquez and Ranking Member Graves for allowing me to share the American College of Physicians (ACP's) views regarding the President's Health Care Budget for Fiscal Year 2010.

I am Jeffrey P. Harris, MD, FACP, the President of the American College of Physicians, a general internist for three decades, who worked as a Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 40,000 people. I am pleased to be able to represent the College today at this hearing.

The American College of Physicians is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical students. Approximately 50 percent of our members involved in direct patient care after training are in practices of five or fewer physicians and 20 percent of these physicians are in solo practices. These practices are medicine's small business so ACP appreciates the opportunity to deliver its perspective to this committee on the President's health care budget for fiscal year 2010.

Smaller physician practices are an essential part of the system of care in the United States. A report describing ambulatory care visits provided in physician offices states that ambulatory medical care is the largest and most widely used segment of the health care system, with over 900 million visits in 2006. The report found that approximately 82 percent of office visits are furnished in practices with five or fewer physicians. While about 31 percent of office visits are provided in the solo practices, 46 percent are furnished by single-specialty groups with 22 percent provided in multi-specialty practices.

We are pleased that the President's budget provides a down payment on health care reform and provides an opportunity for Congress to address the issues of physician payment reform, expanding access to health care coverage, the primary care workforce shortage, health information technology, and comparative effectiveness.

Funding for Physician Payment Reforms

Accounting for the Costs of Preventing Medicare Physician Pay Cuts

We are grateful that the President's budget recognizes a shortfall in the current Medicare payment formula and intends to dedicate funding to account for "additional expected Medicare payments to physicians over the next 10 years."

Over the past several years, one of the College's main priorities has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate, or SGR. This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices. Although Congress has acted to avert scheduled Medicare payment cuts in the last several years, it has not acted to permanently fix the flawed payment formula. Unless Congress acts to provide the funding necessary to fix this flawed Medicare payment formula, physicians will face continued uncertainty over Medicare reimbursement rates in the future.

Dr. Peter Orszag, who heads the White House's Office of Management and Budget, had this to say in testimony before the House Budget Committee:

> "Our Budget includes the Administration's best estimate of future SGR relief given the agreed-to fixes for Medicare physician reimbursement in past years. As a result, projected deficits are about $400 billion higher over the next ten years than they would otherwise be. In contrast, past budgets accounted for no SGR relief in any years. (Although our Budget baseline reflects our best estimate of future SGR relief given past policy actions on SGR, as discussed below we are not asserting that this should be the future policy and we recognize that we need to move toward a system in which doctors face stronger incentives for providing high-quality care rather than simply more care.)"

Accounting for funds needed to reform the flawed sustainable growth rate (SGR) payment formula could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts.

Since 2002, Congress has stepped in just about every year to enact temporary "patches" to stop the SGR cut, but has not come up with a permanent replacement. Rather than accounting for the difference between the lower amount mandated by the SGR, and the higher amount paid out under the patch, Congress assumed that the higher spending will be made up with even an even deeper SGR pay cut the following year.

This is why the "patch" for an estimated 5 percent SGR cut in 2008 resulted in a scheduled 10.5 percent SGR cut in 2009. And why the patch for the 10.5 percent SGR cut in 2009 balloons to a scheduled 21 percent cut in 2010.

No one really expects, though, that the 21 percent cut will go into effect. As in past years, Congress is expected to pass legislation to prevent the cut. This time, though, Congress has an opportunity to do it in a way that accurately accounts for the costs rather than masking them.

Since this is a hearing of the Committee on Small Business, the following analogy may help illustrate the problem. Imagine you worked for a small business, and imagine that your boss told you that your wages would be cut by 10 percent this year.

Later, your boss announces that your company will not cut your wages, but that the only way the company can afford to stop the 10 percent cut will be to pretend to reduce your wages by 20 percent the following year. She tells you not to worry, though: they will just do the same thing next year - prevent the 20 percent cut by pretending that the cost will be made up by cutting your wages by 40 percent the following year. She adds, though, that the company has no intention of ever allowing the 40 percent cut to happen. They just have to pretend they will so their accountants will allow them to stop the immediate pay cut.

No small business would actual run its payroll budget this way. Yet this is how Washington has handled costs associated with stopping the SGR.

President Obama's budget is a marked departure from past practices, because it acknowledges what we all know to be true, which is that preventing pay cuts to doctors will require that Medicare baseline spending be increased accordingly. To be clear, the College understands why Congress and the previous administration resorted to paying for temporary SGR fixes by assuming cuts in later years. The reason was to eliminate the necessity of finding hundreds of billions of budget offsets under pay-as-you go rules.

It is not that our physician-members and their patients do not recognize and appreciate the actions that Congress has taken in the past to stop the SGR cuts. It is just each time this has been done, the accumulated cost of finding a long-term solution has increased.

ACP recognizes that some "deficit hawks" may be troubled by President Obama's proposal to acknowledge the true costs of preventing deep and sudden cuts in payments to physicians. ACP understands this concern, but also believes that accurate budgeting is a pre-requisite to fiscal responsibility. Masking the costs of stopping the SGR cuts does not make the cost go away. It just hides it, making the true cost of the next "patch" even greater, creating an insurmountable barrier to a long-term solution.

ACP urges committee members to make a formal request to your colleagues on the House Budget Committee and to the leadership of the House to incorporate into the budget resolution *an accurate accounting of the true costs over the next 10 years of*

providing physicians with positive updates in lieu of the SGR pay cuts. The budget resolution should further stipulate that this increase in Medicare baseline spending assumptions would not be subjected to pay-as-you go offsets.

Once the true costs are accounted for in the budget, Congress and the administration should enact a long-term solution that will permanently eliminate the SGR as a factor in updating payments for physicians' services. Instead, payment updates should provide predictable increases based on the costs to practices of providing care to Medicare patients. This is especially important for physicians in smaller practices, where Medicare payments are not keeping pace with their overhead costs.

Reform of Medicare Payments to Support Primary Care

The Institute of Medicine recently reported that 16,261 additional primary care physicians are now needed to meet the demand in currently underserved areas. Two recent studies project that the shortages of primary care physicians for adults will grow to more than 40,000.

The primary care shortage is escalating at a time when the need for primary care physicians is greater than ever. Our aging population is further increasing the demand for general internists and family physicians. In addition, increasing numbers of patients with multiple chronic diseases is also increasing the demand for primary care.

Even though decades of research tells us that primary care is the best medicine for better health care and lower costs, the current U.S. health care system fails to support policies and payment models to help primary care survive and grow. More than 100 studies, referenced in ACP's recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care. Congress should enact Medicare payment reform so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the under-valuation of primary care by Medicare and other payers compared to other specialties.

- A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared to other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge.

- A recent study compared residency position fill-rates with average starting salaries by specialty and found that U.S. medical students tend to choose more highly compensated specialties. For example, the lowest average starting salary of any specialty was family medicine ($185,740) while the highest average starting salaries were in radiology and orthopedic surgery ($414,875 and $436,481). In 2007, only 42.1 percent of first-year family medicine residency positions were filled by U.S. medical school graduates compared to 88.7 percent in radiology and 93.8 percent in orthopedic surgery.
- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates.
- One author suggests that achieving a national goal of 50 percent of clinicians practicing in primary care will require "improving the payment gap between primary care physicians and specialists such that the generalist-to-population ratio increases."

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association--200842and Merritt Hawkins – 2008 Review of Physician and CRNA Recruiting Incentives – Top Twenty Searches]. This compensation gap is contributing to a growing shortage of primary care physicians, and particularly primary care physicians in smaller practices.

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.

- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.

Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate

student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

Other countries have made investments to increase pay to primary care physicians to make them competitive with other specialties, and have found such investments to be effective in attracting more physicians to primary care. The new contract for the English National Health Service "helped increase recruitment into primary care and was advantageous to family physicians, whose incomes increased 58 percent between 2002-03 and 2005-06.

The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare pay a bonus for primary care services furnished by physicians whose practices focus on primary care. While MedPAC would defer to Congress to determine the precise bonus payment amount, it identifies the 10 percent bonus currently paid for services furnished in health professional shortage areas and the 5 percent bonus that was previously provided for services in areas with a low physician-to-population ratio as a starting point for discussion. MedPAC initially made this recommendation in June 2008—when it devoted an entire chapter in its Report to Congress to "Promoting the Use of Primary Care"—and reiterated it in its March 2009 Report to Congress "to emphasize its importance." The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as can be more readily done for tests and procedures—to increase their revenue.

Redefine Budget Neutrality Rules Relating to Increased Payments for Primary Care

ACP appreciates the MedPAC attention to the payment disparity problem. The MedPAC recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services, however, deviates from the College's position. The College believes that the funding should not be restricted to budget neutral adjustments in the Medicare physician fee schedule and instead should take into consideration the impact of primary care in reducing overall Medicare costs, including costs under Part A associated with reductions in preventable hospital, emergency room and intensive care unit visits associated with primary care.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

To illustrate how much can be saved by creating payment incentives for primary care, a recent study in The American Journal of Medicine found that "higher proportions of primary care physicians [in each metropolitan statistical area] were associated with significantly decreased utilization, with each 1 percent increase in the proportion of

primary care physicians associated with decreased yearly utilization for an average size metropolitan statistical areas of 503 admissions, 2968 emergency department visits, and 512 surgeries." (Kravet, et al, Health Care Utilization and the Proportion of Primary Care Physicians, The American Journal of Medicine, February 5, 2008).

It stands to reason, then, that Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases targeted to primary care.

It also is not clear whether MedPAC intends for the adjustment to be a one-time adjustment or one that is sustained and continued over several years until the market compensation gap between primary care and other specialties is closed. The College believes that a one-time adjustment, even if it is as high as 10 percent, will be insufficient to make primary care competitive with other specialties. In addition, the amount of the adjustment should not be left up to Congress to decide each year, but should instead be scheduled in advance so that annual compensation increases in increments until parity is reached with other specialties. Such predictability is needed to influence the career decisions of medical students and associates who are contemplating the current and future potential of primary care compensation, as well as to established primary care physicians who may be contemplating a career change or early retirement.

Funding for Programs to Support the Patient-Centered Medicare Home

The Patient-Centered Medical Home enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement the demonstration currently being developed that focuses on practices that use advanced HIT. Other bills have been or are likely to be introduced that would direct additional Medicare medical home test projects.

Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payer PCMH tests, many involving multiple health plans, underway or being developed across the country.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability. While practices must demonstration capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations focusing on improving transitions in care, e.g. inpatient to ambulatory

setting, in certain geographic areas [cite QIO 9th SOW]. The Department of Health and Human Services maintains a program that facilitates the ability of physicians to provide language translation services to patients. The federal government should provide sufficient funding for programs to help smaller physician practices qualify as PCMHs.

In addition, the current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot.
The budget should also provide states with dedicated federal funding to implement PCMH demos for Medicaid, SCHIP, and all-payer programs.

The Commonwealth Fund's Commission on a High Performing Health Care System recently issued a report that advocates that the federal government "Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention." The report estimates that widespread implementation of the medical home model would reduce national health care expenditures by $175 billion over ten years.

Budgeting for Comprehensive Health Care Reform

President Obama has proposed a $634 billion fund for comprehensive health system reform.

The College strongly supports the concept of creating a dedicated source of funding for health reform, but we have not taken a position on the administration's specific proposals to pay for this fund. For instance, the fund would be paid for in part by targeted reductions in spending on specific programs funded by Medicare, including Medicare Advantage plans, hospitals with high rates of re-admissions, Medicare Part D drug pricing, and increasing the contributions of higher income beneficiaries to Part D. We agree that spending on Medicare needs to be carefully evaluated to determine if there are savings in certain areas that could be re-allocated to comprehensive health care reform, but recommend that Congress obtain more specifics on the Medicare savings proposed by the administration, seek input from the public and key stakeholders on such savings, and consider potential alternatives. The College does support the administration's goal, of leveling the playing field in Medicare payments to Medicare Advantage plans and traditional Medicare.

On March 9, ACP joined 29 other advocacy groups representing physicians, hospitals, consumers, patients, insurers, and many others in a joint letter to the House and Senate budget committees. The letter urges that the congressional budget resolution provide the resources needed to enact comprehensive health reform legislation. The letter makes the

point that the Congressional Budget Office's current scoring rules do not recognize many of the savings to be achieved by a restructuring of the health care system:

> "In our view, such legislation should include effective provisions to reduce costs by improving the quality and efficiency of health care and help ensure coverage for every American. Legislation of this kind will reduce the rate of growth of both federal and private health care expenditures, and will thus improve the fiscal health of the nation. While the cost savings from improving the efficiency and quality of health care will be significant, many of the anticipated savings will be realized in the long term, and may thus not be evident in a ten year budget window. Moreover, CBO's current scoring conventions do not recognize many of the savings to be achieved by a restructuring of the health care system. We believe, therefore, that it would be reasonable to develop an approach for health care reform that reflects both the near-term exigencies and long-term savings of such extraordinary legislation. Requiring spending or revenue offsets for the entire cost of health reform within a ten year budget window, as required under a traditional pay-as-you-go rule, will significantly reduce the likelihood of enacting legislation to achieve essential reforms for long-term savings."

Accordingly, the College urges committee members to recommend to your colleagues on the House Budget Committee and House leadership that the committee develop a more flexible approach to pay-as-you-go for health care reform that reaffirms the importance of offsets, but accommodates the need for significant short-term expenditures that will help set the health system on a path toward significant long-term savings and improvement in the long-run fiscal future of our country.

Other Budgetary Priorities

Health Information Technology

ACP appreciates the $19 billion investment included in the Economic Recovery Act that will continue efforts to further the adoption and implementation of health information technology. We support the positive Medicare payment incentives for physicians who acquire health information technology and use it for meaningful purposes, like reporting on quality measures or using it to remind patients to get recommended preventive services. Starting in 2015, the legislation will subject physicians to Medicare payment cuts if they are "non-compliant."

The College believes that it is imperative that the overall environment be hospitable to the purchase of certified EHRs before imposition of penalties that would reduce baseline payments to physicians not using certified systems beginning in 2015. While penalties will not adversely affect physicians for some time, small and/or rural practices, which are in the greatest need of assistance, stand to lose the most if penalties take effect before the barriers to their HIT adoption and use are addressed. The American Recovery and Reinvestment Act

requires or sets in motion activities to create an environment in which EHRs that harness the potential of the technology—including the establishment of standards and processes—are commonly available. However, there is no guarantee that challenges will be met in the timeframe envisioned.

While Congress could pass legislation delaying payment penalties or otherwise amending the current law (and the current law does permit exemption from penalties for hardship, term yet-to-be defined, cases), it is prudent to identify goals, with associated time frames, that must be met and to establish a process by which penalties are reassessed when certain time frames fail to be met. Specific benchmarks that reflect the needed progress should include but not be limited to: certifying the sufficient availability of HIT at a cost that avoids imposing an unreasonable barrier; and certifying that technical capabilities, including functionality and interoperability, are applicable to small and/or rural practices, especially those that furnish primary care, to enable successful adoption and use. Imprudent HIT purchase in the face of impending penalties would be devastating to these practices.

ACP urges the House Committee on Small Business to exercise oversight of the HIT incentives program included in the American Recovery and Reinvestment Act Economic Recovery Act, and specifically, to hold HHS accountable for making sure that the overall environment is hospitable to the purchase of certified EHRs before penalties are imposed, especially on smaller practices that will face the greatest challenges to HIT adoption.

Comparative Effectiveness Research

ACP strongly supports the $1.1 billion in additional funding included in this legislation to support research on the comparative effectiveness of different medical treatments. The Healthcare Effectiveness provisions included in the American Recovery and Reinvestment Act will build on the excellent, but limited and inadequately funded, comparative effectiveness activities currently being engaged in by the Agency for Health Research and Quality (AHRQ) and the National Institutes of Health. They are an excellent first step towards the future establishment of an adequately funded, independent, trusted, national entity to prioritize, sponsor and/or produce trusted research on the comparative effectiveness of healthcare services. They will create jobs associated with hiring more researchers and development of tools to effectively integrate comparative effectiveness research into clinical decision-making at the point of care, and will have an even greater and lasting benefit to the economy.

The Congressional Budget Office (CBO) estimates that providing $100 million to comparative effectiveness in 2010 and allowing this to grow to $400 million through 2019 would reduce total spending on health care in the U.S. by $8 billion during 2010-2019. $8 billion in health care savings will translate directly into lower health care costs for employer and employees. Funding of the research in the larger amounts should result in even greater savings.

Summary and Conclusions

Physicians in smaller practices have a tremendous stake in the decisions that Congress will make this year on the federal budget. Congress has an historic opportunity this year to adopt a budget that will help physicians in smaller practices provide the best possible care to patients by:

- eliminating payment cuts from the SGR and accounting for the true costs associated with providing updates that reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions
- increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices
- modifying Medicare budget neutrality rules to allocate a portion of anticipated savings associated with primary care, such as from reduced preventable hospital and emergency room admissions, to fund increases in payments for primary care services
- funding programs to support and expand the Patient-Centered Medical Home
- creating a dedicated federal fund for comprehensive health care reform, while allowing for further analysis of the administration's proposals to pay for it, including consideration of potential alternatives
- developing a more flexible approach to pay-as-you-go rules in the context of health care reform, one that reaffirms the importance of offsets while accommodating the need for significant short-term expenditures that will help set the health care delivery system on a path toward significant long-term savings resulting in improvement in the fiscal future of our country over the long term
- continuing to fund a Medicare incentive program to provide positive incentives for physicians to acquire heath information technology and to use it for meaningful purposes, but with oversight to assure that the overall environment is hospitable to the purchase of certified EHRs before penalties are imposed, especially with regard to smaller practices that face the greatest challenges to HIT adoption.
- increasing funding for research on comparative effectiveness to inform clinical decision-making

ACP appreciates the opportunity to share its views regarding the President's budget and outline the College's priorities for health reform. We remain committed to working with you and your colleagues in the Congress to pass legislation that will improve the quality and lower the costs of our health care system.

Statement
of the
American College of Surgeons

Presented by

John T. Preskitt, MD, FACS

before the
Committee on Small Business
United States House of Representatives

"The President's FY 2010 Budget and Medicare: How Will Small Providers be Impacted?"

March 18, 2009

Chairwoman Velazquez, Ranking Member Graves and Members of the Committee, thank you for holding this important hearing on Medicare policy proposals included in the President's Budget and their impact on small business providers and the patients they serve. My name is Dr. John Preskitt, and I am a general surgeon in private practice at Baylor University Medical Center in Dallas, Texas. As a Fellow of the American College of Surgeons (ACS) and a member of the ACS Board of Regents, I am honored to testify on behalf of the more than 74,000 ACS members regarding the President's budget and its impact on surgical practices and the patients our members serve.

I have been in private practice in general surgery and surgical oncology at Baylor since 1981. Seventy-eight percent of our members also practice in an office-based private practice. The average practice has five surgeons and 15 employees.[1] We must purchase health insurance and other benefits for our employees. We too are small businesses, and we struggle to maintain viable employment opportunities for our employees. And in all fairness, we are a very blessed profession.

Before turning to Medicare, I do want to express the ACS's appreciation for the President's commitment to healthcare reform in his budget. While there are many details to be sorted out along the way, the ACS applauds the overarching goals of President Obama's health care reform effort to expand access, improve quality, and reduce the growth of spending. These are goals that we share, and the ACS looks forward to working with the Administration and the members of this Committee on this important effort as the process moves forward. The ACS shares the belief that attention should be paid to initiatives that reward care that improves quality and reduces cost, and we are hopeful that these efforts will build on many of the successful initiatives undertaken by the ACS and our colleagues in medicine. Many of these efforts from the government's perspective have already started within the Medicare program, and it is widely expected that Medicare physician payment reform will be included in this effort. So it is appropriate that our conversation start with Medicare reimbursement.

M dicare Physician Reimbursement

Our member surgeons, on average derive 38 percent of their revenue from Medicare.[1] These surgeons feel the effects of Medicare's policy changes most directly because it is Medicare policy, particularly regarding reimbursement, that in large part determines the viability of their practices and their ability to continue to serve their patients.

Medicare's physician payment system is broken and needs to be replaced with a more reasonable structure that keeps pace with rising practice and liability costs and yet still provides healthcare value for our patients. If this system is not fixed, the people who stand to lose the most are the patients who depend on these physicians for care. Because of the sustainable growth rate (SGR), the Medicare method of calculating physician reimbursement, Medicare payments to physicians will be cut 21.5 percent on

[1] Characteristics of Office-Based Physicians and Their Practices: United States, 2005–2006 Data From the National Health Care Survey, April 2008.

January 1, 2010, if Congress fails to act. In fact, since the SGR first required a 5.4 percent reduction in payments in 2002, only congressional action has prevented additional cuts in each of the following years. On a couple of occasions, including last July, Congress has had to retroactively reverse cuts that had previously taken effect.

The ACS is grateful for the overwhelming bipartisan support that members on this Committee and the House of Representatives offered last July in passing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which reversed the 10.6 percent cut in Medicare physician payments that had taken effect earlier that month. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's—before adjusting for inflation.

The College appreciates the President's recognition that the current Medicare payment system is not sustainable or realistic if our nation is to have enough physicians to meet the health care needs of Medicare beneficiaries and our population as a whole. It is widely believed by members of both parties that the SGR is broken and should be reformed. The President's budget would provide $147.1 billion over the next 5 years and $329.6 billion over the next 10 years to initiate important and essential reforms to Medicare's physician payment system. Through this funding, the President's budget would reset the budget baseline for the SGR and would ensure that Medicare payments to physicians would not fall below current levels. According to some estimates this dollar amount could provide payment increases of up to one percent per year. With such a demonstrated commitment, the ACS believes reform that recognizes rising practice costs, provides the right incentives for quality care, and ensures that patients can access the care that surgeons and our colleagues in medicine provide can be achieved.

While Medicare physician reimbursement will have the most immediate and obvious impact on surgeons, surgical practices, and surgical patients, the President's budget includes other proposals that could also impact surgical practices and patient access to surgical care. Given that the Budget Outline was a broad document, it is our hope that the Administration and Congress will keep an eye to patient access to quality surgical care as it considers how and whether or not to ultimately pursue these policy proposals.

Hospital Payment and Quality Improvement

One of the significant areas of reform included in the Budget Outline is hospital payment reform. While our members are paid separately from hospitals, surgeons are the critical component of the care delivered in hospitals, and surgeons and hospitals work together to serve patients facing a major illness, disease or injury. If hospitals do not have surgeons, hospitals cannot survive and patients in the surrounding community are

forced to travel great distances to seek surgical care. Likewise, our members cannot serve patients if there is not a hospital with whom to partner in caring for patients.

An area of both promise and potential pitfalls is the proposed expansion of the current hospital quality improvement (QI) program. While the budget does not address this directly, some have proposed expanding hospital quality improvement efforts and hospital payments to include surgical care. In order to ensure the expanded program's success, it will be essential that the hospital program and the Physician Quality Reporting Initiative (PQRI) be in harmony to improve and not impede quality surgical care. As a result, if surgical care is included in this effort, it is critical that the perspective of surgeons and others who are caring for these patients be considered. In addition, if surgical care is included, risk-adjustment to account for the wide-range of patient acuity will bring not only accountability but also added respectability that will yield the buy-in from hospitals, surgeons, and other stakeholders needed to ensure the program's success.

If surgical care is included in these QI efforts, the public reporting of performance data regarding specific hospitals becomes vital. As you know, the Centers for Medicare & Medicaid Services (CMS) already publicly reports certain hospital measures, but the addition of surgical care would require an added complexity and degree of caution. If surgical care is included, ensuring appropriate risk-adjustment will be absolutely critical to ensure that hospitals and surgeons are not penalized for caring for high-risk and severely ill patients. The ACS is concerned that at present there are considerable limitations with the public reporting of hospital quality information. These limitations were recently chronicled in the November/December 2008 issue of *Health Affairs.*[2] In the article, some hospitals listed as top performers in one survey were listed toward the bottom of another and vice versa. Before reporting this type of data to the public, it will be necessary to ensure that the measures being used are recognized by clinicians as true measures of quality and not simply proxies for what a payer, private or public, or a consumer may interpret as quality care. One such proposed proxy has been to define "high quality" providers as those, who on a review of claims data, perform the highest number of certain procedures. Such proposals could have particular impact on rural and other underserved areas where general surgeons care for a wide range of patients with a wide range of conditions, diseases, and injuries. Many rural, frontier and even some urban communities already face an emergency and surgical workforce crisis, and, if not done carefully and accurately, public reporting could serve to threaten patients' ability to access care in these smaller communities. The public reporting of data that has not been appropriately aggregated and risk-adjusted could lead to incentives that eventually drive surgeons and patients away from these rural communities to hospitals in larger cities. Such a result would not only bring added inconvenience to patients as they seek acute health care services, but it would also threaten the future of hospitals in these smaller, rural communities. These rural hospitals not only serve an important economic function in smaller communities, but they also serve as a safety net when

[2] Michael B. Rothberg, Elizabeth Morsi, Evan M. Benjamin, Penelope S. Pekow, and Peter K. Lindenauer, "Choosing the Best Hospital: The Limitations of Public Quality Reporting," *Health Affairs* 27, no. 6 (2008): 1680-1687.

patients are in need of emergency surgical care. The distance a patient travels before receiving the necessary care can often be the difference between life and death. As a result, it is of the utmost importance that appropriate safeguards be developed to ensure that public reporting does not threaten access to care in rural and underserved communities and that any reported data be based on sound clinical information with thorough testing before being released to the public.

In raising these cautions and concerns, I want to stress that the ACS also sees these QI efforts as an opportunity to build on successful efforts already underway in hospital quality improvement. Based on a highly successful effort within the Department of Veterans Affairs, which decreased VA post-surgical mortality by 27 percent over 10 years, the College has spearheaded the ACS National Surgical Quality Improvement Program (ACS NSQIP) in private hospitals across the country. ACS NSQIP is a prospective peer-controlled, validated database that quantifies 30-day risk-adjusted surgical outcomes, allowing for comparisons among all participating hospitals. After a pilot to test NSQIP in three non-federal hospitals in 1999, the ACS applied for a grant from the Agency for Healthcare Research Quality in 2001 to expand the program to 14 hospitals. Based on its successful application in these hospitals, the ACS has since expanded the ACS NSQIP program to include 220 hospitals nationwide. The Joint Commission already acknowledges the value of participation in ACS NSQIP and includes a Merit Badge next to the profile of all ACS NSQIP hospitals. It is important to note that ACS NSQIP also gathers data under the Surgical Care Improvement Project (SCIP), which has been offered by some for possible inclusion in future hospital QI payment reforms. As Congress has appropriately set incentives for physician participation in registries that satisfy the requirements of PQRI, the ACS believes that ACS NSQIP, a database already in existence, could similarly support efforts to design a meaningful hospital QI program for patients.

In addition to supporting the hospital QI expansion, the ACS NSQIP's use of 30-day risk-adjusted outcomes could also support the President's proposal to bundle hospital payments to cover not just the hospitalization but to cover care from certain post-acute providers provided within 30 days after hospitalization. Just as a successful hospital QI expansion must have risk-adjustment so must any proposal that would penalize hospitals with higher readmission rates. To simply punish hospitals with higher readmission rates, without accounting for the severity of patient's illness or other conditions that could lead to complications, could have adverse consequences for hospitals, surgeons and ultimately, the sickest of patients that they are seeking to serve.

Physician Ownership and Specialty Hospitals

One area of significant concern for our members is the general reference in the outline's summary lines to "[a]ddress financial conflicts of interest in physician-owned specialty hospitals." Because the outline does not offer specifics and does not cite scored savings or cost, it is difficult to respond to a specific proposal. It is well known that there is a concerted effort to deny physicians the right to invest in hospitals and other facilities that offer patients alternative treatment settings. In my home state of Texas, hospitals

and healthcare systems have partnered with surgeons and medical specialists to develop hospitals. This is a similar model to that which has been followed by hospital-physician partnerships in forming ambulatory surgery centers. These have been shown to provide a high quality, cost-effective alternative to hospital outpatient departments.

Recent proposals considered by Congress would not immediately eliminate existing physician-owned hospitals but would limit capital investment in existing facilities while ending the prospect of building and developing specialty hospitals in the future. Benefits of these physician-owned hospitals can include more cost-effective care; lower infection, complication and mortality rates; shorter hospital stays; and increased patient satisfaction. These hospitals can complement our very fine community hospitals and academic medical centers. If our nation's health policy is to be consistent with efforts to promote better quality and value in patient care, it makes little sense to no longer allow patients the option to receive care at facilities, which in many cases have been shown in government-sponsored studies to produce very good outcomes and have high patient satisfaction.[3]

In addition to limiting patient choice in care, there would also be a significant impact on the people who work at these hospitals, their families, and the economy in the surrounding community. These facilities employ 55,000 people, including nurses, other health professionals, and support staff.[4] Measures limiting the ability of the facilities to improve and expand would certainly threaten these jobs as these facilities age. In addition, proposals that would disallow the development of physician-owned hospitals will not only threaten capital investments in communities but will threaten numerous associated jobs in construction and infrastructure required to build and prepare these facilities for delivery. This is an economic time in which our communities cannot afford further job losses. Imposing new limits on physician-ownership and investment in these facilities would most certainly lead to job losses and economic hardship for these facilities' employees and families.

The ACS recognizes that legitimate concerns have been raised by the actions of a few physician-owned hospitals, but this does not mean that all physicians should be punished and denied professional opportunities. Instead, the ACS has consistently held that physician-owned hospitals and their physician-owners should operate under the following principles:

- Accept all patients for which they can provide appropriate care, without regard to source of payment.
- Patient selection should be based on medical criteria and facility capabilities. Patients with needs that extend beyond a facility's resources should be referred

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[3] Michael O. Leavitt, Secretary of Health and Human Services, *Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Centers for Medicare & Medicaid Services: 2005.

[4] Physician Hospitals of America, "Congressional Action Could Harm Physician Hospitals, Economic Impact Could Be Severe," Press Release, 13 Jan. 2009. 16 Mar. 2009 http://www.physicianhospitals.org/documents/PHArelease011309National.pdf.

to a tertiary care center or other hospital that is appropriately equipped and staffed.

- Surgeons practicing in specialty hospitals should maintain their commitment to providing the emergency services needed in their communities and should take call in community hospital emergency departments, as necessary.
- The issue of whether specialty hospitals should have their own emergency rooms is, and should remain, a matter of state law and community need.
- Physician investors should disclose their financial interest to patients they propose to treat in a specialty hospital.

Across America and across physician specialties, many physicians, from family physicians to radiologists to surgeons, own their individual practices. However, much of the care surgeons provide takes place outside of the office-based setting and within a hospital or ambulatory surgery center (ASC). For over 30 years, surgeons and hospitals have partnered with each other as owners and investors in ambulatory surgery centers that deliver high quality surgical care for less cost. It should follow that surgeons be afforded the same opportunity to own or invest in their place of practice, whether that place is an office, ambulatory surgery center, or hospital.

Preserving a Surgical Workforce for the Future

While outside the scope of Medicare, the ACS also appreciates that President's recognition of the workforce challenges facing our health care delivery system by providing $330 million for health care provider workforce shortages in certain areas, and to expand loan repayment programs for physicians, nurse, and dentists in medically underserved areas. The programs referred to in the President's budget do not include surgeons and focus largely on primary care. While many raise concerns about the adequacy of the nation's primary care workforce, it is important to note that the care these physicians provide is just one component of our nation's health delivery system, and primary care is not alone among physician specialties in facing a workforce shortage to meet the needs of patients. The ACS and others have continued to warn that the nation's health care workforce challenges extend beyond primary care, and we are already seeing signs of an emerging national crisis in patient access to surgical care.

One of the areas where the ACS has seen this crisis emerging most rapidly and most acutely is among our nation's general surgery workforce. General surgeons are specifically trained to provide comprehensive surgical care, and because their expertise is broad, they are qualified to manage a wide variety of medical conditions. These conditions range from cancer to gastrointestinal disease, from endocrine tumors to ruptured aneurysms, from hypertension to breast cancer, and for the care of the injured patient. When patients require complex, multi-system care, a general surgeon can fill the gap between other physician specialties. In the case of major trauma, general surgeons are frequently on the frontlines of emergency care, saving lives on a daily basis.

Last April, the *Archives of Surgery* published an analysis of the trends of the general surgery workforce between 1981 and 2005.[5] The analysis showed that the number of general surgeons as a proportion of the population declined by 26 percent during that 25 year period. While this decline was felt in both rural and urban areas, rural areas continued to have significantly fewer general surgeons per capita than their urban counterparts. In addition, whereas in 1981, only 39 percent of the general surgeons practicing in rural areas were between the ages of 50 and 62; now, over 50 percent are between the ages of 50 and 62. Further complicating the outlook for general surgical care, the *Archives* study showed that while the number of general surgical residents has remained fairly static at approximately 1,000 per year since 1980, increasing numbers of general surgical residents are specializing. Whereas in 1992, a little over half of all general surgery residents entered a fellowship, now over 70 percent of all general surgery residents choose to pursue a fellowship.

Other research shows that general surgery is not alone among surgical specialties facing both current and future workforce challenges. The Dartmouth Atlas compiled surgical workforce data showing a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively.[6] Further, the Bureau of Health Professions (BHP) projects an increase of only 3 percent among practicing surgeons between 2005 and 2020—with projected declines in thoracic surgery (-15%), urology (-9%), general surgery (-7%), plastic surgery (-6%), and ophthalmology (-1%). Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.[7]

With trauma care and surgical emergencies, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist. Surgical training is vastly different from other physician training programs. Mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Surgical residencies require a minimum of five years and often several more years for specialties such as cardiothoracic surgery. However, the prospects of declining payment coupled with rising practice costs; increasing liability premiums and the escalating threat of litigation; a crippled workforce leading to more on-call time, higher caseloads, and less time for patient care; and an uncertain future for the U.S. health care system understandably deter would-be surgeons from making the extra sacrifices necessary to become a surgeon.

The ACS has developed several proposed measures and would be open to other solutions that improve patient access to surgical care and ensure the needed surgical

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[5] Dana Christian Lynge, Eric H. Larson, Matthew J. Thompson, Roger A. Rosenblatt, and L. Gary Hart, "A Longitudinal Analysis of the General Surgery Workforce in the United States," *Archives of Surgery* 143, no. 4 (2008): 345-350.

[6] Figures compiled through analysis of data available at the Dartmouth Atlas website at: http://www.dartmouthatlas.org/atlases/98Atlas.pdf, http://www.dartmouthatlas.org/atlases/99Atlas.pdf and http://cecsweb.dartmouth.edu/atlas08/datatools/datatb_s2.php?geotype=SPL_HRR&year=2006.

[7] Bureau of Health Professions, Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020.* October 2006.

workforce in the future. First, it is important to support existing residency programs and to promote the development of additional residency programs, particularly in rural areas. In addition, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career, while also, as much as possible, eliminating the disincentives that push medical students away from the surgical profession. To this end, the ACS would encourage the members of this Committee to strongly consider the following policy options:

- Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps.
- Fully fund residency programs through at least the initial board eligibility.
- Include surgeons under the Title VII health professions programs, including the National Health Service Corps (NHSC) program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training.
- Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas.
- Extend medical school loan deferment to the full length of residency training for surgeons.
- Allow young surgeons who qualify for the Economic Hardship Deferment to utilize this option beyond the current limit of three years into residency.
- Increase the aggregate combined Stafford loan limit for health professions students.

The College also supports legislation that seeks to increase the number of residency training programs. At present, a majority of residency training programs exist in or near major metropolitan cities. While the current programs continue to excel at producing high quality surgeons, they do not adequately distribute surgeons to communities across the nation. A major obstacle preventing the establishment of new residency training programs are the costs associated with the creation of such programs. The Physician Workforce and Graduate Medical Education Enhancement Act (H.R. 914), which was introduced by Representative Michael Burgess, MD (R-TX) and Representative Gene Green (D-TX), would establish an interest-free loan program where hospitals committed to starting new residency training programs in one or a combination of seven medical specialties, including general surgery, could secure start-up funding to offset the initial costs of starting such programs. By providing a greater number of residency training programs in underserved areas, the surgical workforce shortage could be reduced for many states. In addition to the measures previously discussed, the ACS believes this legislation would be an appropriate step toward addressing the workforce challenges we are witnessing in rural areas. The ACS will continue to support this and other legislation that helps ensure patient access to surgical care.

In spite of these payment trends and the workforce challenges just outlined, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed

increased Medicare reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. While not included in the budget, the ACS is concerned that some may want to include such measures in Medicare payment reform. Such proposals, while seeking to promote efforts to help Americans better manage their care, would further exacerbate the workforce challenges previously described and ironically establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. The ACS supports efforts to prevent disease and to promote wellness not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur. As a result, it is critical that Congress take steps now to ensure a stable surgical and a stable physician workforce for all Americans.

The ACS greatly appreciates the opportunity to testify before the Committee regarding the President's budget and its impact on surgical practices and patient access to surgical care. The prospect of meaningful and lasting health reform and Medicare payment reform offers much cause for hope but we should proceed with caution as well. Increasing Americans' access to health insurance coverage will have little value if Americans cannot obtain the care they need from the appropriate physician. That is why we must carefully consider what has worked and what has not. The ACS believes that the patient must be our guide on Medicare physician reimbursement, quality improvement, physician ownership, workforce or any other issue considered in the context of health reform. The American College of Surgeons stands ready to work with the members of this Committee, the Congress and the Administration on this important effort to reform our nation's health care system and to ensure that all Americans will continue to have access to quality surgical and medical care for years to come.

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Testimony
of the
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before the
Committee on Small Business
of the
U.S. House of Representatives

"The President's Budget and Medicare:
How Will Small Providers be Impacted?"

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Good afternoon Madam Chairwoman. I am Edward Hannon, CEO of McDowell Hospital in Marion, North Carolina, and Chairman of the American Hospital Association (AHA) Small or Rural Hospital Governing Council. I am here on behalf of the AHA's nearly 5,000 hospitals, health systems, networks and other health care provider members, including almost 1,700 small or rural hospitals.

The McDowell hospital is a 65-bed, rural, not-for-profit hospital, which employs more than 300 people, and is set in the foothills of the Blue Ridge Mountains of western North Carolina, or as we like to say, "where main street meets the mountains." The hospital provides care to about 2,000 inpatients a year and offers a wide range of health care services to our community, including obstetrical, oncology, emergency and surgical care, as well as various social, family and wellness support services.

THE PRESIDENT'S BUDGET

In the budget outline released last month, President Obama called for reducing the deficit, enacting health reform and retooling our nation's entitlement programs. We are steadfast in our commitment to health care reform, which ought to start with expanding coverage for all. We commend the President for making health reform a top priority among the many challenges facing our nation.

Furthermore, we support efforts to make health care more affordable, such as focusing on wellness and prevention; better coordinating care; eliminating physician-self referral to hospitals in which they have an ownership interest; utilizing comparative effectiveness research to determine the most effective care; moving toward the adoption of information technology; creating alternative liability systems; and reducing administrative costs.

Given the economic pressures faced by hospitals, which serve as the nation's health care safety net, and given that Medicare already pays hospitals less than the cost of providing services, it is essential to proceed with caution with respect to health care reform, as hospital services for people in need have already been cut at the state and local levels. We are concerned about cuts that affect the work hospitals do for their communities during this economic downturn.

THE UNIQUE CHALLENGES OF RURAL HOSPITALS

Our hospital is like many rural hospitals that dot the landscape of America: We are there to serve our community's needs to the best of our ability, regardless of what those needs might be.

I am pleased to be here this afternoon to testify before this committee on the impact the President's budget outline will have on small or rural hospitals. Specifically, I would like to give you an idea of the unique nature of small or rural hospitals, and, accordingly, how the budget proposals will affect us.

There are three main characteristics of rural hospitals: smaller size and volume, geographic isolation, and the type of population served. Understanding these important issues is critical to understanding how federal health care policy affects rural areas.

SMALLER SIZE MEANS LOWER VOLUME AND LOWER PROVIDER SUPPLY

Current federal policy regarding payment, quality, and safety measures does not adequately account for the differences in the inpatient volume of rural hospitals. As a rule, rural hospitals treat fewer patients, which translates into a substantially smaller "sample size," making interpreting data difficult and, at times, misleading. This small sample size means that the ability to average out or smooth the data is diminished, which tends to give undue weight to aberrant events or circumstantial anomalies.

Lower patient volume also translates into a financial position that is much less predictable, complicating long-range financial forecasting and contingency planning. This makes small and rural hospitals less able to weather financial fluctuations, especially in today's economic environment. For example, our inpatient average daily census routinely fluctuates between 10 and 35 patients; this much variance presents many challenges for us when planning staffing and budgeting.

Rural hospitals also have a difficult time attracting and retaining highly skilled personnel, such as doctors and nurses. One impediment is the lack of commonly available family and social amenities, as well as other conveniences. As a result, many rural patients must travel a relatively long distance for care, a factor that often creates longer intervals between visits or between diagnosing and treating the original or latent conditions.

GEOGRAPHIC ISOLATION

Rural communities are self-contained and far from population centers. Often, the local hospital is far from another population center or health care facility. In my case, the closest hospitals to McDowell are over 30 miles on the other side of the mountain to the west, and about 25 miles to the east. Public transportation is rare and, if it does exist, it is sporadic. For example, in my community, there is no public transportation; the only transportation program that exists is a recently implemented county program that provides transportation for Medicaid patients to their medical appointments. In addition, for many rural communities, inclement weather or other forces of nature can make transportation impossible or, at the very least, hazardous. The inability to rely on safe, consistent transportation for many rural residents means that preventative and post-acute care, pharmaceutical and other services are delayed, or in the extreme, forgone entirely, which can increase the overall cost of care once services are delivered. All of these factors complicate the treatment and care protocols of primary care physicians and again, ultimately, increase the cost of care.

LARGER SHARE OF MEDICARE BENEFICIARIES

America's rural areas have a high proportion of Medicare patients. At my hospital, Medicare accounted for 58% of our discharges in fiscal year 2008. Because we have a high population of Medicare patients, any payment changes or cuts in the program have a disproportionate affect on us. When coupled with our low revenue flow, the problem is compounded because we operate on extremely small margins. We are less able to subsidize losses and to adjust our budget strategy based on our changing patient mix and volume.

This unique set of demographic and public policy circumstances exerts considerable negative financial pressure on America's rural hospitals and, for many, threatens their long-term financial sustainability. This in turn threatens the health and welfare of rural America.

THE BUDGET'S IMPACT ON SMALL/RURAL HOSPITALS

Now that I have provided this background, I would like to outline how these issues intersect with several of the proposals in the administration's budget outline.

As I said, we may be considered small hospitals, but the impact rural facilities have on our communities is large. Rural hospitals are partners and providers of first, second and last resort in countless small towns, villages and reservations all over our country. The geographic realities, isolation and large coverage area means that we are THE medical center for, in some cases, hundreds of miles. There simply is no other option. We see it all, treat it all, and must stand ready to handle a wide range of medical and public health situations, whether caused by man or nature. These unique circumstances require stable and predictable financial resources and manpower, both of which, as I outlined earlier, tend to be in short supply. It is for these reasons that small or rural hospitals have been early and ardent proponents of reforming our health care system.

Now, Madam Chairwoman, I would like to take a moment to share our views about the readmissions, bundling and pay-for-performance proposals in the President's budget outline.

READMISSIONS

The President's budget outline contains a provision to reduce payments to hospitals with high numbers of patients readmitted within 30 days. The proposal is projected to save $8.43 billion over 10 years. Determining preventable readmissions is a complex undertaking and must be thoroughly analyzed before policies can be adopted. The use of readmission rates is concerning because it does not fully account for all the circumstances involved in a readmission. The use of a readmission rate would seem to be an arbitrary judgment that all readmissions are preventable. That is not the case. While some readmissions are clearly under the control of the hospital, most are the result of a complex series of conversations, circumstances and medical decisions that involve hospitals, physicians and other providers who manage patients' care, as well as patients and their families.

Let me give you an example of the factors that come into play when a rural hospital readmits a patient. An elderly patient was admitted for a small bowel obstruction. Her surgery was successful and her physician recommended a skilled-nursing facility (SNF) for post-acute care. However, as is very common in small, rural areas, she is fiercely independent and refused to go to the SNF. As a result, her condition worsened, and she had to be readmitted. We persisted in working with her and she eventually did agree to skilled care, but only after two more admissions for the same diagnosis.

Further, some readmissions are planned and appropriate patient care – such as for repeated chemotherapy treatments or reconstructive surgery following trauma. Any provision that does not recognize these legitimate reasons for readmission may become an obstacle to patient care and safety.

BUNDLING

The President's budget outline contains a provision to bundle payments for hospital and post-acute care, which is projected to save $17.84 billion over 10 years. In our view, we welcome any option that decreases the cost of care and increases patient quality, but any changes should be the result of careful, thoughtful research. The need for studied evaluation of existing demonstration projects in this arena, phasing-in implementation gradually and providing the appropriate tools and infrastructure for coordinating care and managing risk must be integral to any new plan. Our members recognize that payment systems are fragmented and paying providers based on volume is not a strategy for an efficiently run, coordinated health care system. Some of our members are organized in ways that would facilitate bundling payments, but many are not, and they need the tools to be able to operate in this manner.

As it appears in the President's budget outline, bundling of hospital and post-acute payments is problematic. We believe that there are other bundling methodologies that could improve care coordination and promote efficiency.

As a rural hospital CEO, bundling raises many questions. For example, many of the pilot projects that have explored the effectiveness of bundling have focused on care that is not commonly given at rural hospitals, such as for coronary artery bypass graft surgery. Would bundling of payments be effective and feasible for the care that rural hospitals commonly do

provide, such as chest pain and chronic obstructive pulmonary disease? Understanding the care process, the unique obstacles rural health care faces and the needs of rural patients will be crucial if we are to shape a fair and coherent payment bundling system.

We have serious concerns about the underlying assumptions of bundling on small and rural hospitals. Most bundling proposals posit that if hospitals control the payment bundle, they will select the most appropriate, effective post-acute care provider. The underlying assumption of bundling is that a hospital will have the option to choose the highest-quality and lowest-cost provider. However, there is often little, if any, choice in rural areas due to low provider supply; there is also less capacity, and wait times for post-acute care can be long.

For example, we have three home health agencies in our county, which is a high number for a rural area. The largest agency has a very limited number of physical therapists. As a result, there is often a two-week delay in patients being able to access these services, and in some cases, the agencies will decline referrals because they are at capacity.

Travel times, distances and other common rural circumstances have a profound effect on the frequency and ability of the patient to obtain post-acute care and therefore impact the efficacy of care. As an example, one of our elderly patients was admitted with a hip fracture and needed post-acute home health care. However, her living conditions were not conducive to healing, as her home was unhygienic. Unfortunately, this is not an uncommon situation. Predictably, her condition worsened and she was readmitted for other complications that were unrelated to the quality of care she received in the hospital.

How will these limitations affect the feasibility and advisability of implementing bundling in rural areas? Right now we simply do not know. Therefore, more study and analysis must occur before we embark on bundled payment arrangements in rural areas.

PAY-FOR-PERFORMANCE

The President's budget outline contains a provision to link a portion of inpatient hospital payments to performance on specific quality measures, which is projected to save $12.09 billion over 10 years. Providing incentives for improving quality through pay-for-performance or value-based purchasing are areas worthy of consideration. Hospitals, more than any other provider type, have a history of linking quality measurement and improvement to payments. However, we are concerned about the proposal in the budget for value-based purchasing that would cut payments up-front, since we believe overall savings can be achieved by improved care leading to fewer medical visits.

The goal of incentive approaches should be to improve performance. The use of payment to change incentives in today's health care system should reward providers for demonstrating excellence in improving quality and patient safety and providing effective care. Using these approaches as cost-cutting measures is of particular concern for rural hospitals because of our low volume. Again, this low volume could lead to rural hospitals having fewer resources and lower margins, which makes these potential payment cuts even more devastating.

In addition, we have many questions about how pay-for-performance will be implemented in rural areas. Specifically, some hospitals may have limited data available for certain measures because of their low volume – they may not often deliver the services that feed into the measures being used. For these hospitals, their data may not be statistically stable or sufficiently indicative of their real performance to enable meaningful participation in a pay-for-performance program, i.e. one patient could have a disproportionate effect on the score of a certain measure. A way to address low volume situations must be included in any pay-for-performance proposal.

Along these same lines, current proposals use a standard set of measures, which may involve procedures not performed at all small or rural hospitals, and hospitals cannot report on procedures they do not do. We are concerned about whether and how these limitations will be taken into account when crafting pay-for-performance policy – if they are not adequately considered, it will put small and rural hospitals at a distinct disadvantage. The concept of rewarding performance excellence holds merit and I believe that rural hospitals offer high quality care. However, we are concerned that some of the approaches used will result in payment penalties, inequities and other serious consequences – intended and unintended – for hospitals and the communities they serve, particularly those in rural areas.

Finally, there are several provisions in the President's budget outline that we strongly support: inclusion of permanent reform for the Medicare physician fee schedule; strengthening the health professions workforce; and a ban on physician self-referral.

MEDICARE PHYSICIAN FEE SCHEDULE FIX

We strongly support the President's proposal to permanently reform the Medicare physician fee schedule. Medicare has been slated to cut physician payments by a significant amount for many years. Although the cuts have been prevented each year, the repeated threat puts physicians in a very difficult position and many physician practices will not be able to remain viable under Medicare if the cuts go through. Rural areas have a very tough time recruiting physicians because of our low volume and geographic isolation. And when coupled with our high proportion of Medicare patients, these repeated difficulties with Medicare physician payment make recruiting infinitely more difficult.

For example, we have been able to successfully recruit seven physicians in the past year. However, we have only been able to do so by agreeing to employ them at the hospital, which places an enormous risk, burden and cost on us, as we must guarantee their salary, provide benefits and assume billing responsibility. Unless employed by the hospital, these physicians felt that their payments would not be steady and reliable enough to ensure that they would be able to maintain a viable practice. This is both because of the low, and often unpredictable, volumes in rural areas, as well as the sustained threat of cuts to Medicare payments.

Permanently reforming the Medicare physician fee schedule will substantially aid our ability to recruit and retain physicians.

STRENGTHENING THE HEALTH PROFESSIONS WORKFORCE

The President's budget outline invests $330 million to address the shortage of health care providers in medically underserved areas, many of which are rural. For many of the same

reasons we support reforming the physician fee schedule, we also support this proposal. As I outlined above, rural areas often have a very difficult time attracting and retaining health care providers.

For example, after 17 years, our two obstetricians left the hospital, citing poor quality of life, including the fact that one or the other was required to be on call at all times, as well as the constant decline in reimbursement rates. While we eventually recruited new physicians, for several months we were forced to pay a hefty price to employ temporary physicians. Their services are at a premium and the commuting cost to our hospital was extraordinary. When we did find physicians who agreed to practice in our community, it was only as an employee of the hospital. The business model for private practice did not make sense. This need to employ our doctors is a large burden and puts the hospital at risk – if the physician does not receive sufficient reimbursement to cover his or her salary, the hospital covers the difference. In this case, we are bearing a loss, as obstetrical services are not appropriately reimbursed.

BAN ON PHYSICIAN SELF-REFERRAL

We strongly support the President's inclusion in his budget outline of a ban on physician self-referral to hospitals in which they have an ownership interest. We look forward to working with the administration and Congress to achieve this goal.

CONCLUSION

Madam Chairwoman, hospitals are more alike than different. No matter where we are, no matter the size of our institution or community, we exist to heal and to help anyone who needs us. This is the rich heritage of America's hospitals.

However, as I have explained today, there are unique concerns that apply to rural hospitals. Any budget proposal must recognize how health care is delivered in rural America. I ask that you and your colleagues ensure that we embrace a federal policy that understands and enhances our ability to provide the care our rural communities expect and every patient deserves.

Thank you for your time today.

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CONGRESSIONAL TESTIMONY

The President's Budget And Medicare

Testimony before
Committee on Small Business
United States House

March 18, 2009

Robert E. Moffit, Ph. D.
Director, Center for Health Policy Studies
The Heritage Foundation

Mr. Chairman and Members of the Committee:

My name is Robert E. Moffit. I am the Director of the Center for Health Policy Studies at the Heritage Foundation. I previously served as a Principal Deputy Assistant Secretary of the United States Department of Health and Human Services during the Reagan Administration. The views that I express today are entirely my own, and should not be construed as representing the views of the Heritage Foundation, its officers or its Board of Trustees.

President Barack Obama has outlined an ambitious and far-reaching health care agenda, including major changes in the Medicare program. It should be noted that even before the President held his White House health care summit, the Congress had already enacted key elements of the President's health policy agenda. This includes the expansion of the State Children's' Health Insurance Program (SCHIP), estimated to cost approximately $65 billion over ten years. It also includes health provisions in the recently enacted "stimulus" legislation, including additional funding for Medicaid, COBRA, investments in health information technology, and the establishment of a research program for "comparative effectiveness" into different medical treatments and procedures, drugs and devices. Altogether the estimated 10 year cost of these initiatives amounts to $136 billion.

The President's Agenda In the President's submission, he is asking Congress to adopt a health care funding proposal to create a reserve fund for comprehensive health care reform that would amount to an estimated $634 billion over ten years. The objective of this proposal is to create systemic changes in the health care system that would lead to universal coverage and also to enact specific health care policies that would result in an annual reduction of $2500 in the typical American family's health insurance premium costs.

The President is also inviting "good ideas" from across the political spectrum to achieve substantive improvements in the health care system. The President's decision, in this respect, is wise. It is a refreshing departure from the contentious history of previous attempts to forge federal health care policy. Comprehensive health care reform should be a genuine bipartisan undertaking. It should take into account the simple fact that while there are common objectives that all or most Americans sincerely share, there is also strong disagreement among Americans on the best way to achieve reform. When proposals are presented clearly, and the tradeoffs are also presented clearly and honestly, it is not uncommon for support for specific health policy proposals to decline, sometimes dramatically.

Congress should build on points of agreement on goals, and attempt to narrow disagreement on the means. Clearly, there is broad agreement on the need to radically reduce the number of Americans who are uninsured. There is also a widespread recognition of the need to take decisive steps that would result in greater value for the dollars that are spent on health care, as well as to eliminate gaps and inequities in health care coverage, financing and delivery, including racial and ethnic disparities. There is no

widespread agreement on the role of government, or the specific way in which government should influence or control the financing and delivery of health care services.

I would only observe that the decision to start with the financing of the health care reform without a clear understanding of what it is exactly that would be financed beforehand is, at the very least, an unusual approach. I would make two observations. First, while the President may believe that there is enough of an agreement to jump start the process by putting the money up front and hammering out the details later, it is the common experience in this area of public policy that it is the details that drive the broad policy agenda; not the broad policy agenda that necessarily drives the details. Secondly, with funds already committed to the project, there is the danger that existing stakeholders, the representatives of the powerful class of special interests that dominate this sector of the economy(doctors, hospitals, health plans, pharmaceutical and biomedical research interests) will view this entire effort as merely a way to expand existing public and private institutional arrangements, with the ample benefits of additional taxpayers' dollars, rather than a process of securing real, structural change in the health care system: the creation of different ways of improving the financing and delivery of health care for the 300 million Americans who would be the beneficiaries of real reform.

Financing Reform. The President's proposed budget outlines in broad terms what methods he will employ to secure the projected $634 billion health program. It should be noted at the outset that the actual cost of reform is likely to be higher, perhaps exceeding $1 trillion over ten years. This would follow a familiar pattern: the true costs of health care proposals are invariably higher than the original government projections.

Broadly speaking, the President is proposing to fund health reform by two methods. First, he is proposing tax increases on higher income Americans that would amount to $318 billion over ten years, He would also secure savings through various delivery reforms, such as the broader use of Health IT and the comparative effectiveness, and changes in the federal entitlements, especially Medicare and Medicaid. Together, these would amount to $316 billion over ten years.

Medicare Changes. The President is proposing major changes to Medicare Advantage, Medicare Part D, and the traditional Medicare fee for service program. Altogether, he is proposing dozen Medicare-related changes. In the limited time available, I would like to focus my remarks on a few key Medicare budget proposals.

Medicare Advantage Plans are increasingly popular and now enroll roughly one out of five senior citizens, and provide richer and more varied packages of benefits than available under traditional Medicare. Richer benefits mean that these plans cost more by an estimated 12 to14 percent compared to traditional Medicare, which is governed by a system of administrative payment. The President estimates this change would account for $176.6 billion over ten years.

The President proposes instead to have private health plans in Medicare offer bids in geographic area of the country, and then pay the plans on the basis of the average of these bids. This is potentially an attractive change to the Medicare program. Much would depend on how the legislation is crafted, the details of the process and what the Administration means specifically by "competitive bidding". It is a phrase that can have very different meanings. If the process is a way for the government to pick "winners and losers" among health plans, something akin to a DOD procurement process, it would be incompatible with personal choice and market competition among competing plans. It is well to recall that the provision of that opportunity, particularly for seniors in rural areas, was one of the major reasons why Congress created the Medicare Advantage program in the first place. If it is a way of establishing a more rational benchmark for Medicare payment, and allowing persons to pick richer health plans and pay for the extra benefits, if they wish to do so, or picking less expensive health plans and keeping the savings of those choices, the President's proposal could be a significant improvement over the current system.

The President is also proposing to make wealthy seniors pay higher premiums for prescription drugs. According to press reports, seniors enrolled in Medicare Part D would pay higher premiums just as seniors do today in Medicare Part B. The President projects that this change would achieve a savings of $8.1 billion. Congress is faced with a $36 trillion unfunded liability in the Medicare program over the next 75 years, and within the next three years the first wave of the 77 million baby boom generation will start to retire. This means that the Medicare program will experience the largest demand for medical services in its history. Simply cutting provider reimbursements to control costs, as has been done in the past, are unlikely to maintain the provision of high quality health care to the nation's senior and disabled citizens. Income-relating Medicare subsidies, as the President has proposed, are a sound alternative.

The Administration wants to change hospital payment by providing a flat fee to hospitals for the first 30 days of hospital care, and lower payments for hospital readmission. This is projected to achieve a ten year savings of $8.4 billion. The proposal is designed to create incentives for hospitals to provide higher quality care and reduce the need for additional hospitalization. The objective makes a great deal of sense; once again, Congress should study this to make sure that it does not engender any unintended consequences in the provision of hospital care. In health policy, unfortunately, unintended consequences are common and costly.

The Administration also calls for re-evaluation of current provider payment systems, promotes "pay for performance" in accordance with government guidelines, and tougher enforcement and oversight of Medicare payments to doctors and other medical professionals to reduce waste, fraud and abuse. The Medicare "pay for performance" proposals were also promoted by officials of the Bush Administration to secure greater value for health care dollars. But, once again, depending on how they are crafted, they could very easily generate unintended consequences, such as "gaming" by physicians who would have a new economic incentive to focus on certain patients at the expense of others. Likewise, waste, fraud and abuse has been a staple of Medicare cost cutting for

many years, but too often physicians have been audited and investigated for coding errors as well as intentional efforts to defraud the taxpayers. It might be more fruitful for Congress to see what can be done to reduce the regulatory overhead that physicians and other medical professionals must incur in the treatment of Medicare patients.

It should be noted that Medicare savings have previously been proposed as a way to finance broader health care coverage, but with limited success. In 1993, for example, President Clinton proposed shifting $124 billion out of Medicare, capping Medicare spending over a six year period, to fund his comprehensive health care reform program. Since Medicare currently pays only 81 percent of the cost of private physician payment, for example, it is quite likely that if the President's changes simply result in additional reimbursement reductions, they would aggravate the current level of cost shifting from federal entitlements to private sector health insurance arrangements. Tens of billions of dollars of cost shifting annually does not add one red cent to the value of patient care.

In any case, modifications of Medicare's administrative payment system do not amount to major Medicare reform. That can only be accomplished by changing Medicare financing from defined benefit to defined contribution, and creating a Medicare retirement program that more directly resembles the Federal Employees Health Benefit Program (FEHBP), which is often cited favorably by health policy analysts of many different political persuasions in the media and elsewhere.

Tax Policy. As noted, the President is proposing tax increases on those making over $250,000 annually, and is projected to finance approximately half of the projected health care spending, an estimated $318 billion. The mechanism would be a reduction in tax deductions for these citizens, including mortgage interest and charitable deductions. Congress will have to decide if the Administration's tax proposals are themselves in the best interest of the country or the best way to secure reform of the health care system under the current economic circumstances.

But renewed discussion of the current tax policy governing health insurance could open up a new opportunity to forge a bipartisan consensus in health policy. From the late President Ronald Reagan and great economists such as the late Professor Milton Friedman to Senator Ron Wyden (D-OR) and Jason Furman, one of President Obama's senior economic advisers, there is an enormous intellectual consensus on the need to reform the inequitable and inefficient federal tax treatment of health insurance.

Today, the federal tax code provides unlimited tax breaks for individuals who get health insurance through the place of work. This tax exclusion for employer-sponsored insurance is a huge, but hidden, tax subsidy. The Joint Committee on Taxation estimates that value of the tax exclusion was $246.1 billion in 2007 alone, in foregone income and payroll taxes. It is the largest federal tax expenditure as well as the third largest health care expenditure, following only Medicare and Medicaid, the nation's two largest entitlement programs.

Health economists generally agree that existing tax policy is poorly targeted and engenders perverse incentives. It is unfair because only individuals with employer-

sponsored insurance are able to receive tax relief, while individuals without access to such coverage typically pay for health insurance with after-tax dollars and, in effect, face a sizeable tax penalty. It is inefficient and inequitable because the largest tax benefits go to those who need them least: upper income individuals and families. If the goal is to extend coverage to the uninsured, the tax break is poorly targeted because it provides little or no tax relief to those with low incomes, who are most likely to have difficulty getting affordable health insurance.

It also increases health care spending. Of course, the exclusion does encourage individuals to have insurance. As Jason Furman, the President's Deputy Director of The National Economic Council, has noted, the current tax policy also encourages many individuals to have even more insurance than they typically need because the higher the cost of the insurance, and the higher the person's income, the bigger the tax benefit for the individual. Out-of-pocket expenditures, for the most part, do not enjoy a similar tax preference. This incentive reduces the price sensitivity of health care consumers and suppliers and leads to higher prices and greater utilization, which in turn drives up cost and makes health care more expensive for the uninsured.

The best option for reform would be to replace the existing tax exclusion with a universal system of more equitable individual tax relief, leveling the playing field for a robust competition among insurers and creating a level of consumer choice that is routine in every other sector of the American economy.

Short of that, Congress could limit or cap the exclusion, while simultaneously using the new revenue to provide health care tax credits for taxpaying households. Senate Finance Chairman Max Baucus (D–MT) has suggested limiting the current tax exclusion. The Baucus approach is ground for a possible compromise, forging a system of direct assistance to the uninsured through a combination of tax credits and vouchers.

If Congress were to cap the tax exclusion, revenue generated from the value of premiums that either exceeds the cap or is no longer excluded from taxable income could be used exclusively to finance tax credits to individuals and families to offset their federal taxes. The health care tax credits should apply to a significant portion of a health plan's premium, and used to offset some of a taxpayer's income tax liability. In no case should the credit or voucher be used to cover an entire premium, even for very low income persons; it is impossible to get cost control in health care, where financing is notoriously opaque, unless consumers have some skin in the game.

For low income persons who have no tax liability, Congress could provide health care vouchers. For persons with only limited tax liability, some combination of a tax credit and voucher could make health insurance more affordable. The voucher component would be somewhat like a traditional refundable tax credit, like the earned income tax credit, although with a key difference. These health care vouchers should be financed by offsets in the budget, including reductions in existing health programs. Congress can find plenty of options available to finance such direct assistance to low-income persons, and make the trade-offs according to their prudential determination of what should rank as a priority in the public interest. A voucher approach for the education of low-income

schoolchildren is endorsed by Democrats and Republicans alike; there is no reason why Congress could not pursue a similar option in health care.

In any case, Congress should not leave in place the existing tax exclusion for health insurance, the most regressive feature of the federal tax code, which distorts health insurance markets, undercuts consumer choice and competition, and fuels higher health care costs.

These conclude my formal remarks. I would be very happy to answer any questions that the Committee may have.

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The AMA supports physician-owned hospitals. They increase competition in the hospital industry, and deliver myriad benefits to their communities - high-quality, state-of-the-art care; reduced average lengths-of-stay; high levels of patient satisfaction; and high staff satisfaction. They also employ thousands of people in the communities they serve and provide local access to state-of-the-art specialty care.

Physician-owned hospitals have achieved better quality, greater efficiency, and higher patient satisfaction than general hospitals. Government-funded studies have found that they have lower risk-adjusted mortality rates and postoperative complications. Physician-owned hospitals are able to achieve production economies by taking advantage of high volumes of a narrow scope of services, and by lowering fixed costs by reengineering the care delivery process. They improve patient access to specialty care by providing additional operating rooms, cardiac-monitored beds, and diagnostic facilities. They offer newer equipment, more staff assistance and more flexible operating room scheduling, thereby increasing productivity and allowing for physician autonomy over their schedules. Moreover, patients at specialty hospitals enjoy greater convenience and comfort such as lack of waiting time for scheduled procedures, readily available parking, 24 hour visiting for family members, private rooms, more nursing stations closer to patient rooms, decentralized ancillary and support services located on patient floors, and minimized patient transport.

MedPAC and CMS have found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital. Data also show that there is no difference in referral patterns between physician-investors and non-investors, proving that ownership and profit are not the driving factors in referring to specialty hospitals. In fact, the majority of physicians who admit patients to specialty hospitals have no ownership interest and thus receive no financial incentives to refer patients to them.

If arbitrary restrictions on physician-owned hospitals were to become law, many highly rated hospitals, including some that provide care to medically underserved rural communities, would have no choice but to reduce employment or close. It would mean a loss of thousands of good jobs and would greatly limit the choices patients have when they need specialty care. During a time of economic peril, this would be antithetical to the critical goals of enhancing access to quality care and stemming rising unemployment.

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